T R I C A R E
RETAIL PHARMACY (TRRx)
PRE-PROPOSAL CONFERENCE

April 3, 2003

Doubletree Hotel, Denver Southeast
13696 E. Iliff Place
Aurora Colorado 80014

TRANSCRIPT OF TAPE RECORDED PRE-PROPOSAL CONFERENCE

PANELISTS

MR. DON KALIL, Contracting Officer.

MR. ROBERT SEAMAN, Representative for General Counsel.

GENE MAYS, Program Requirements Office.

LT. COL. DON DeGROFF, Pharmacy Benefits Office,

COL. WILLIAM DAVIES, Program Manager for Pharmacy, Director, Pharmacy Benefits Management Office in Falls Church.

COL. DAN REMUND, Director, Pharmacal Economic Center, San Antonio.

RUSS MOULTON, Price Cost Analyst.

CARL AKINS, Resource Management Office.

MR. KALIL: How many from industry were not here yesterday if I could see a show of hands. Okay. I'll just briefly go over the ground rules again for those that weren't here yesterday.

Again, if there are any potential amendments to the RFP, you will see those in writing. Nothing that takes place during the conference, either yesterday or today, will lead to any changes, unless you actually see them in writing. So I just want to make that stipulation, again.

Going back to the information security, physical security and personnel security, were there any questions that were developed over the evening that you would like to ask at this point in time? Okay. That's a good sign, I guess. Okay. Great.

What I would like to do now is just a slight change in the agenda, an addition to the agenda. I'd like to bring Mr. Seaman up here, and he wants to make some clarifications, with regard to the security requirements.

MR. SEAMAN: Since there weren't any questions based upon yesterday's meeting, I think I will make some comments, and maybe generate some questions.

There was some discussion afterwards by some of the governmental personnel as to whether or not there was a slight misimpression that was given yesterday. And it goes to the last sentence here of this particular provision.

As Dorothy indicated yesterday, if you have a contractor, stand-alone system, in other words, a contractor operator system that does not connect to a DoD system, we have allowed in this procurement, the option or the alternative of not doing background checks on the Level III personnel.

There was some indication yesterday, or what was stated yesterday about what was acceptable in lieu of the background checks, we did not want to give the wrong impression that the bar was lowered, or something less than the background check. What this last sentence basically says is, the standard remains a background check.

If you want to come in with a plan, or you have an existing commercial plan that is comparable to a background check, or comparable to the process by which we would certify trustworthiness, we will entertain that plan and we will look at it.

Some of that plan was addressed by Dorothy yesterday to be training, non-disclosure statements, that kind of thing, all of which should be in your plan.

The idea here is that rather than going through a

background check, if you don't want to go through a background check to get a certificate of trustworthiness, then the burden is going to be on the contractor to certify or be responsible for the trustworthiness of their employee at that level.

So what we're looking for is a plan that is somewhat comparable to a background check, but shifts the burden to you, if you want that burden to basically certify or be responsible for the trustworthiness of that individual. I assume that most businesses do that anyway.

You have some kind of review or you come to some sense of security that you're hiring an employee that will in fact be trustworthy. All we're looking for is, if you don't want to go through the background check process, that's the plan we will be looking for to approve.

Are there any questions or comments on that?

MR. KINNUMEN: This is Mark Kinnumen from Express Scripts. You said a stand alone system that does not connect to a DoD system. In my mind, a stand-alone system is when it doesn't connect to anything. So if I have a system that connects into PDTS, which is not a government system, which in turn connects to a government system, does that supply what you're talking about?

MR. SEAMAN: Yes. What we're talking about it direct connect to a government system.

MR. KINNUMEN: Okay. So not a truly stand-alone, then. Okay. Thank you.

MR. SEAMAN: I hope I didn't misuse the technical terms. I'm not a techie. We're talking about a contractor operated system. Okay. Thank you.

MR. KALIL: Just a couple of follow-up items from yesterday. The transcripts that will be provided to me will be posted on the web site. Hopefully we'll have those on there by the beginning of next week.

The slides that we have here will also be posted on solicitation web site. And we will accept any and all questions up until April 14th, and we'll close out at that point in time, unless I notify you that there's a change to that. Any questions on any of that? Any other administrative matters that you have questions on? Yes.

MALE VOICE: Can you hear me?

MR. KALIL: Yes.

MALE VOICE: Can you tell us when the questions that have been asked so far will be posted?

MR. KALIL: Our intent is to get the questions posted as quickly as possible. Understand that we have a -- we want to make sure that we get the right answers out there.

We've received approximately 120 questions so far. Most of those have been answered. We're just going through and

making sure, again, that we provided the exact right answer.

We want to try and do that within ten working days after we receive the question. The majority of the questions that have been asked already we have answers to, and we will be posting those, also, the first part of next week.

Again, if you have any questions, we want your questions, and we will take those questions either through the cards in the packets. If you don't have a packet, I saw some more packets out front there.

We'll take questions during the course of today's events, and if you have other questions after this is over, please submit those through the solicitation web site, retail.solicitation@tma.osd.mil.

Also, my name a number is here, but you'll also notice that in the solicitation itself, Bob Brown's name is in there as a point of contact. Bob is the contract specialist, if I'm not available, or just go straight to Bob. Feel free to do that.

Bob is going into the solicitation mail box, as well as I am. His phone number and e-mail address is provided in Section L, of the solicitation.

We have a somewhat different panel today. I'll introduce them. Starting here on my left, Gene Mays, Program Requirements Office. Gene will be going into significant

detail about the solicitation today.

Then Lt. Col. Don DeGroff is with the Pharmacy Benefits Office, down in San Antonio.

We have Col. Bill Davies, who you met yesterday. He is the Project Officer for TRRx.

Col. Dan Remund, is the Director of the Pharmacal Economic Center in San Antonio.

Russ Moulton, is our Price Cost Analyst on this proposal.

And then Carl Akins Russ Moulton, Price Cost Analyst on this proposal. Carl will be giving you information, and answering questions with regard to payment, and the TEDs process, if necessary.

Just briefly want to go over the CLIN structure. This is broken into a transition phase, as well as we have first option, which will be exercised at the time of contract award. And then there are four additional option years.

The phase-in period, we're looking for a fixed unit price there for phase-in, as well as the DITSCAP portion of the phase-in, which is CLIN II. The phase-in is 180 calendar days after award of the contract.

It is a nationwide startup. We're not doing this regionally. When the day comes for implementation, the successful contractor will begin processing prescriptions for

the entire population identified in the solicitation.

And also, within that initial phase up is an initial mailing that will go out to all current retail users.

CLIN II, as we discussed yesterday, is the information security, physical security, and personnel security.

The Admin fees are broken down for Medicare Dual Eligible and TRICARE only, eligible beneficiaries, as well as prior auth. of medical necessity reviews.

The reason why that's broken down is for internal accounting purposes. The question has been asked if there would be different prices proposed for those. Certainly we won't tell you what you include or don't include in your prices, but if there are differences between those two, the solicitation does direct you to submit, other than cost and pricing data, with regard to those differences.

CLIN VI, is for the financial incentive. There is nothing for offerors to put in the proposal with regard to CLIN VI at this point in time. That will only be filled in after contract award, if the incentives are paid out.

With regard to phase out, we will evaluate the highest priced CLIN that is proposed on phase out.

Then again, CLIN VIII is for the ongoing security requirements. Again there's going to be personnel requirements

in there, background investigations. There may be some maintenance costs that will be going inside -- into that CLIN as well, and that will be an ongoing effort.

All the CLINS, with regard to the total price evaluation will be evaluated. You'll notice that, as of right now, this is going to be one of the things that will be subject to a future amendment. In the evaluation portion, we did not say we were going to include CLIN VIII in the total evaluated price. We will be doing that, and that will be in a forthcoming amendment to the solicitation, and II, for the initial phase in, DITSCAP.

Any questions on anything to do with the CLIN structure? Yes.

MR. SANTULIS: A question on CLIN I. When you're talking about the phase in, everything is going to be phased in nationally, 180 days after award.

MR. KALIL: Right.

MR. SANTULIS: Is the plan to make sure that's going to be before the first managed care support contract or at least in conjunction with that, or it could come before all of them?

MR. KALIL: The original intent was to have these coincide with managed care. It doesn't look like that's actually going to happen. Irrespective of manager care, 180

days after contract award.

MR. SANTULIS: Is TMA going to issue a change then to the managed care support contractors?

MR. KALIL: I don't believe I can answer that. I would look to Brian.

MR. RUBIN: I don't want to get into a whole lot of detail on that, Kevin, but the point is, we're bringing this one up all at once. Depending on what happens with the managed care schedule we may have to do some T for C, or what have you, with our current contractors, but that's not a topic I want to get into today in terms of timing, and how we're going to deal with all our current contractors. The point is, this will come up on the date listed in the RFP.

MR. SHAHETKA: Rob Shahetka with Pearson. Statement of Work Provisions, C.19, talks about a beneficiary call service. And prior contracts, like the dual eligibility, we had a separate line item for administrative services which incorporated that call center activity.

Where would you price the call center activity, since all the others are based on claims?

MR. KALIL: The call center activity would go into the admin fee.

MR. SHAHETKA: And those are based on claims? You have numbers of claims in each category. It's not a claim or

it may not relate to a claim. It may be general information.

MR. KALIL: That's true. It's still going to go into the admin fee.

MR. SHAHETKA: It would be calculated as part of a claims processing fee?

MR. KALIL: Yes. It's really just the cost that goes into that admin fee.

MR. HANNETT: Fred Hannett with The Capitol Alliance. Again beating a dead horse, back to national implementation, the Section C talked about coordination with the managed care contractors. I think a number of people assumed that meant the new managed care contractors under the three new awards.

What you're talking about will require additional coordination, then, between this contractor and existing managed care contractors, and the three new contractors?

MR. KALIL: That is correct. Whoever is providing health care at that time, through the managed care support contracts. So it could possibly be the existing four, or the future contractors.

MR. HANNETT: Could you elaborate, or could someone elaborate on why that decision was made to go nationwide, as opposed to as you said, the initial decision was that this would be a rolling start? I think it would be beneficial to the audience to hear some of the thinking behind that.

MR. KALIL: Sure. I think Col. Davies can speak to that very well.

COL. DAVIES: What we did was, we had to sit and game out everything that we had going on with the pharmacy benefit. We have several issues that are on the table right now. One issue is the uniform formulary.

As that final rule is in the process of being published, we had to look at the final rule for the uniform formulary, and how that would affect the pharmacy benefit.

We also looked at the impact of regional implementation, versus a nationwide implementation. The bottom line was that a regional implementation, to correlate to the managed care support contractors, as they implemented, posed a great risk if there was any delay in an individual region standing up, as we currently have the twelve regions, or the incoming contractor coming on board.

So as we looked at that, what we essentially were going to end up having, if we did regionalization, was a disparate benefit. The one major intent of this benefit is to provide portability to our entire beneficiary population. A regional implementation process would not delivery that.

Then we looked at a national implementation, and we felt that there was less risk associated with that, from the standpoint that we only had to go out with a one marketing, one

statement, and that way we did not have a disparate benefit.

We could then coincide the implementation of a uniform formulary with that new benefit, and it kept us from going through a very tedious change of management process of bringing up the UF, Uniform Formulary, under the current contractors, a new contractor, when everybody's attentions are being focused in many different directions.

So as we laid that out, it became very obvious to us that a single, nationwide, single-benefit implementation was the best way to go. I'll be more than happy to entertain questions related to that right now.

MR. HARE: Bill Hare, Meridian Consulting. Could you comment on the thought process on the six-month, versus, perhaps, a nine-month transition as the managed care support contracts has proven that the nine-month has been a success for the consideration of a national startup within six months. What kind of concerns did that bring to you?

COL. DAVIES: We think that the PBM industry, in general, has the high reliability of being able to execute an implementation of coverage in a six-month period. We've gone out to our consultants within the industry, and they stated that six months would be more than adequate, and that many plans, albeit smaller than us, are able to make those types of transitions in even 90 days.

I'll point out that unlike the TMOP, which we did implement in a six-month time frame, you don't require the brick and mortar aspect of processing the prescriptions, you know, physically. It's the electronic processing, and all of that, which stands up.

So the transition of this and the carve out of this is very neatly packaged. It's one that we think industry is very capable completing in a six-month time frame.

MR. SANTULIS: Kevin Santulis from WPS. Col. Davies, since you brought up the topic of uniform formulary, do you have an ETA at this time when the final uniform formulary will be available for viewing?

COL. DAVIES: It'll be before our contract goes in place. I really don't have a date I can give you, but we're making extremely good progress in being able to put that forward right now. So it should be shortly out.

MR. McKAY: Col. Davies, Bob McKay for Pharmacare. One question: with regard to the contractors role in the uniform formulary, if you're going to transition members from a non-uniform formulary scenario to a uniform formulary scenario, I didn't see anything in the statement of work indicating that the contractors would have a role with respect to that transition process. So you envision a role?

COL. DAVIES: Those are covered in the contract,

primarily in the sections concerning prior authorization. Medical necessity and a requirement to be aware of the P & T activities, and attend those P & T activities also.

COL. DAVIES: The other aspect is the implementation of the three-tiered co-pay, which would coincide with the uniform formulary.

MR. McKAY: The only reason I asked is, industry usually has more of a role with prior off. or medical necessity determinations. It's very heavily associated with communication activity, associated around the changes. Do you envision that type of activity?

COL. DAVIES: There is a requirement, and I believe it's under "Marketing," to provide on a monthly basis to the managed care support contractors and their marketing materials, information related to any of the changes that are associated with that.

You'll also see us partnering with the communications and customer support division within TMA, and making sure that we use all available means to communicate those changes, not only through those means but through CNCS.

MR. McKAY: Thank you.

MR. KALIL: Any other questions on the CLINs, CLINs structure implementation? Okay. Great. Gene.

MR. MAYS: Good morning, everyone. I would also

like to thank you for coming, and encourage you, if you have any questions anytime during the presentation, to please ask them.

I have several slides I want to go through, and they're pretty much one topic per slide. So if you'll hold your questions till I get through with the slide, then I think that will make it a little easier.

MR. KALIL: Before Gene gets going, I just want you to know that not every topic within the solicitation is on the agenda. So if you have questions with regard to other topics, if you feel that they fit in, please ask those questions. I know a question came up yesterday about other health insurance. It's not specifically a topic in this agenda, but please feel free to bring it up wherever you think it might be appropriate.

We'll answer questions at the end of the day for those questions that are not necessarily on this agenda.

MR. MAYS: I think this is the point where I'm supposed to have an ice breaker or some really funny joke to tell you all, but my sense of humor is really bad, and I always screw up the punch line. So everybody pretend I told a hilariously funny joke and laugh, and we'll move on here.

First thing I want to talk about it networks. Network coverage and network access. Our network coverage extends over the 50 United States, District of Columbia, Guam,

U.S. Virgin Islands, and Puerto Rico.

If you receive any claims outside of that area, then those claims should be directed to the appropriate contractor. It may be the managed care support contractors responsible for foreign claims, or it may be the TRICARE Overseas Global Remote Contract. It just depends where the claim comes from.

In most cases, though, all your claims will come from here. By the same token, if one of those contractors receives a claim that should have been sent to you, they'll be required to forward that to you.

We also require that you include specialty pharmacy services to support our beneficiaries in that regard. One of the things we want to bring out here is, no pure mail order pharmacies are allowed in your network.

What do we mean by that? In some cases, some of your retail pharmacies may provide the prescription to the beneficiaries through the mail as a convenience. And that's fine, as long as they understand that's a 30 day prescription per co-pay, as opposed to a mail order pharmacy where the beneficiary may obtain a 90-day prescription per co-pay. So there's a little difference there.

One of the things we're also very concerned about with network coverage is that we minimize the disruption to our beneficiaries when we transition from the current contracts to

this new retail pharmacy contract.

To help you out with out, in Section L, at attachment 16.L, we provided a list of all the current pharmacies in the existing networks, so that you can look at those and attempt to bring as many of those as possible into your new networks.

In terms of network access, something a little different here. When you do the evaluation of your network, that's going to be on a pass/fail basis. What we mean by that is at the time you submit your proposal you've got to be able to demonstrate a network that meets a minimum access standards.

We don't mean that you propose a network, but say you've got agreements with various pharmacies that they'll sign a network agreement. You must have a network in place and established at the time you submit your proposal, so it meets these minimum standards.

If you don't, you'll fail that criteria and we will not consider your proposal any further for evaluation. So it's very important that you understand that criteria.

We listed the definitions there for "urban," "suburban" and "rural." These may be found at Section J, attachment 2, and the definitions are based on the Department of Labor Bureau of Labor Statistics.

One other point we want to bring out about that, when you do the evaluation, it's going to be based upon you

submitting your network, meeting the access standards, based on geo-access network software.

We specified in Section L how you should do that, and which version of that you should use. There are different versions there, and we specified that you use a representational model to distribute our population along the same lines as the general population distribution within zip codes. It's very important that you follow that requirement.

Does anyone have any questions about network coverage or network access?

MR. RICKERT: Rory Rickert with Integrated Health Care Services. Can you talk, again, about why you would allow or not allow a mail order only pharmacy in the network? I'll give you an example.

Drugstore.com is in a lot of commercial PBM's retail networks, although they have no walk-in capability. Some beneficiaries may find that beneficial to use drugstore.com to get proposal to get prescription items and non-prescription items. You would have them in the proposal here precluded because they don't have a walk-in capability?

MR. MAYS: Col. Davies will take that one.

COL. DAVIES: We currently have a mail order pharmacy program that supports the Department of Defense. That is the only pure mail order pharmacy program that we will

allow. We believe there is a contract that has already been let for that.

The issue related to mail out of prescription from a retail pharmacies, there are pharmacies that may provide that service to the beneficiaries as a courtesy. There may be other chains, and so forth, that have that capability to mail out.

The big difference is, those beneficiaries utilizing that type of service are still under the rules of engagement for the retail pharmacy. The drugstore.com issue is a pure mail order operation, and therefore, it would compete with our TMOP and therefore is not allowable in our network.

MR. RICKERT: But if they would agree to the prevailing retail rates and retail quantities, would they be precluded?

COL. DAVIES: Yes.

MR. RICKERT: Okay. Thank you.

MR. SPILER: Good morning, Dave Spiler from Medco Health. As a follow up to Rory's question, specific to the speciality pharmacy portion of the bid, there's some language in there which alludes to the permitted use of mail. Can you clarify how you expect and will allow use of mail in specialty pharmacy?

COL. DAVIES: That is a good point, Dave. That is a case where they may be only mailed out, and not just a pure

mail-order type pharmacy.

The specialty pharmacy services that we're alluding to in the solicitation, are primarily those related to the provision of outpatient pharmacy services. The term "specialty pharmacy," if you bring folks from the industry in, you can get ten different definitions of what specialty pharmacy is, and what it covers.

We tried to provide examples of specialty pharmacies, primarily in the realm of compounding. Those pharmacies that may compound certain pharmaceuticals and then are mailed on an outpatient prescription basis to a beneficiary, such as some certain topicals or certain oral products that may have to be administered.

The other example might be specialty drug distribution systems that are imposed by either the FDA, or elected to be followed by the particular pharmaceutical manufacturers. We see a growing trend to those, and we needed to make sure that we had a mechanism that those specialty pharmacies that may provide services, and we'll use Teakason as an example, that those be part of the networks so that those services can be covered for our beneficiary population.

Specialty pharmacies can also be referred to as those pharmacies that provide compounding for HEMOT type drugs that would be administered in a clinic, or under home health care.

Those provisions are not outpatient pharmacy services, and therefore, those types of services would not be considered under this contract.

Specialty pharmacy services that we're looking at, to make sure that we have available, are those that would be provided on an outpatient prescription basis. Does that make it clear?

MR. SPILER: Two other follow up questions, to the network coverage piece. While you've laid out your access requirements in terms of urban, suburban and rural, how will the review team consider the size of the network in its pass/fail evaluation?

MR. MAYS: We're not so much worried about the size of the network. We're worried about whether or not you can meet the access standards. If you meet the access standards with 40,000 pharmacies, that's great. If it take 50,000 pharmacies, that's great.

MR. SPILER: Okay. As a hypothetical, if I'm able to provide network coverage that meets those requirements with 10,000 pharmacies, which may be feasible, versus 50,000 pharmacies, will that be held either in my favor or as a potential negative.

MR. MAYS: We would look at that -- let me give a quick answer, then follow up.

It would technically meet the requirements, although it would undoubtedly be assessed a higher risk rating than one with 40 or 50 thousand pharmacies in it.

MR. SPILER: How will the individual bidder be able to understand and assess the risks associated with setting a network size and presenting a bid?

MR. MAYS: I think you'd want to look at the degree of difficulty a beneficiary would have in getting to one of your retail pharmacies. Also what the risk would be in turnover. With 10,000 pharmacies you risk a turnover that would be far higher than with 40 or 50 thousand pharmacies, I think. Or chances of having a gap in coverage would be greater.

COL. DAVIES: I think if you look at our zip code distribution of our beneficiary population, and if you look at the listing of the pharmacies that have been used by our beneficiary population, right now as provided, it's not the number of pharmacies in our network. It's actually the number of pharmacies by listing or the actual pharmacies that have been used by our beneficiary population.

So far, that is about 38,000 pharmacies have been used by our beneficiary population. So if you take that into account, the distribution by zip code, and the requirement that we have up there under network coverage of minimizing the

beneficiary disruption, then you have to assess your proposal too, as you would be sending that forward.

MR. SPILER: Once the contract is awarded, will the government be able to provide member-specific data to allow the winning vendor to best manage the disruption by potentially being able to communicate with members, and manage it in that way? So can we get member-specific data in that regard?

MR. MAYS: Following award you will be provided with a list of members and addresses, so that you can do the initial mailing to those beneficiaries. So yes, that data will be available.

MR. SPILER: Will that data also include the specific pharmacies utilized by those members in the event we would want to do a mailing, if there was a Delta in the pharmacies that they use, versus what may or may not be in the network, to help us manage the disruption to the beneficiaries?

MR. DeGROFF: Dave, we would consider that upon the award. As you know, the PDTS data system, the respository does have that information there, so we could do that at that point in time. It would be upon award.

MR. SPILER: Okay. Thank you.

MR. PAYNE: Bill Payne from Humana. In reviewing the list of pharmacies that you gave us, based on usage, we've noticed that some of those pharmacies do not exist today, and

that was a historical 2002 file. So I think we kind of understand the issues there. Is there anything special you want when we speak to beneficiary disruption to those folks that historically went to a pharmacy that's not there today?

LTC. DeGROFF: I would think that if you look at the list, and you eliminate the pharmacy, the NCPDP numbers that do not exist at the present time, our beneficiary population has probably moved into that area where there already is another pharmacy that's already located there.

So while you will remove some NCPDP numbers, you can probably judge from the use of the other NCPDP numbers that are current where our beneficiary population is. Because our beneficiaries do not go away.

MR. PAYNE: Thanks.

MR. HUDSON: Hello, I'm Bill Hudson from Humana. I want to follow upon a question, based on the response from Col Davies to Mr. Spiler's question.

Will the TRRx contractor be precluded from supplying what I would call non-self administered products through the retail channel? Such as vaccines and doctor's office administered preparations?

COL. DAVIES: Bill, we'll take that question and respond to it on the web site. I can say today that we do not preclude the beneficiary from obtaining those medications that

would be required to be obtained and then carried to a providers office to be administered. There are instances where a judgment call may have to be made, as far as how that coverage is being provided.

You have the instances where the individuals are married to either a registered nurse or a physician, obtain medications, and that are administered.

Then you have beneficiaries who obtain those medications and then carry those to a providers office to be administered.

MR. KALIL: Bill, would you do me a favor and write that question down on one of the cards that we provided?

MR. HUDSON: I certainly will.

MR. KALIL: Great. Thank you.

MR. MAYS: Any other questions on network coverage or network access? Okay. Good. This is the kind of discussion we were hoping to get, so let's move on to network reimbursement.

Network reimbursement is going to be based totally on the network agreement you establish with your retail network pharmacies. This is not something the government gets involved in.

One of the things we wanted to point out and make sure you're aware of is, these network agreements cannot return

any additional fees, rebates, discounts or premiums from the network pharmacies to the contract. That's something we're a little concerned about and make sure you're aware of.

Basically, the government is at risk for these funds. So any of the funds you collect would have to come back to us. It's just easier not to do it at all.

Talk about the evaluation of your network reimbursement rates. It's going to be based on the total projected program pharmaceutical cost. It's going to be based on all five option periods, based on the data you provide in Table L.1 in Section L, where we've listed the projected prescription volume. We've listed some average AWPs to base that on, and we expect you to put in there what your average discount rates and dispensing fees will be for both brand and generic. We'll use that to develop a projected total government cost, or you will calculate that in Table L.

How are we going to look at that? It's not a part of the cost evaluation. It's a separate factor, and it will be part of the best value determination, along with the technical factors and the cost factor. It will be merged into which offer overall gives us the best value.

We're also going to look at proposal risks on that. And what we're looking at there are your discount rates and your dispensing fees. Are they going to allow you to maintain

that network over time, or are the dispensing fees too low to maintain network pharmacies in the network? Are the pharmacies going to rebel? That's what we'll be looking at there. Anybody have any questions about the network reimbursement or the pharmacy reimbursement?

MR. SPILER: Dave Spiler from Medco Health. The proposal talks about the use of Blue Book AWP as the basis for determining pharmacy reimbursement. Can you clarify that will be 11 digit NDCs that the AWP will be based on, or is there some other basis?

LTC. DeGROFF: Unless I'm mistaken, I don't remember the term "Blue Book" being used in the solicitation. Now maybe it was, but in fact, what we base the AWP on is the first data AWP, and yes, there would be an 11 digit.

MR. HUDSON: Bill Hudson from Humana. In Section C, 6.3, it spoke to there's no rebates or other fees collected from the pharmacy with the exception of recoupments.

I wondered in a lot of cases, audit firms and audits that lead to recoupments assess of fee, for the audit process that's usually a percentage of the claim. Is it the government's intention there, with that exception, that audit fees may be applicable, or are they to be built into the CLIN for the claim? More or less the cost of recouping. Generally, that's a percentage of a recouped amount.

MR. KALIL: Yeah, that would just go into the admin. fee.

MR. McKAY: Bob McKay from Pharmacare. You mentioned a statement that's always a concern to us, is network pharmacies rebelling, which is something I'm sure you don't want to happen.

This may be jumping ahead, but reading the RFP, I have a question in my mind. How can I guarantee the pharmacies they'll be paid if they submit a claim to me, and I process it through PDTS, and I get an eligible member back, and they dispense the drug and a member walks away with the drug.

Is there something that can happen in the preparation of a TED record, which is a post-adjudication activity, that will place that payment at risk?

MR. AKIN: The only thing that could happen post adjudication, I think, would be based on the fact that the government had provided you with incorrect information, or when we somehow determine that the person who claimed to be Col. Davies was in fact not Col. Davies.

There is provision in our process for what we call a good faith payment, so that if the pharmacy dispensed a drug based on a valid ID card, and had written down or taken a photocopy of that ID card, and for some reason, when the adjudication process is complete, we determine that this is a

former spouse who didn't turn in an ID card, which is the typical kind of case that occurs here, we will, in fact, honor the payment to the PBM for the processing and expect that the payment to the pharmacy would go forward.

I don't envision any other instance of that kind of thing happening. There could be delays in terms of processing kinds of things that would delay this, but that would be the primary instance.

MR. McKAY: So I can summarize and I can tell the pharmacies that the response of positive eligibility is a guarantee of payment?

MR. AKIN: It's a guarantee of eligibility. If it turns out that the formulary is in place, and they dispense a drug that is not on the formulary -- a positive response for eligibility is simply a determination on eligibility. There can be other reasons for non-payment that would get kicked out. And all I'm responding to is in terms of the eligibility.

I think here, since we're moving to a formulary, if there was something dispense outside the formulary, without the appropriate prior authorization, that could be a reason for non-payment. There's also the potential of medical necessity issue that could arise post dispensing.

MR. McKAY: But holding all those factors constant that the claim was okay, and there was no issue with respect to

that, and the eligibility indicated that the person was in fact eligible, then that can be construed as a guarantee for a payment?

MR. AKIN: Yes, as far as I know.

MR. McKAY: Thank you.

MR. SANTULIS: Carl, this Kevin Santulis from WPS. A follow up to that, when you were mentioning that, one of the things that came in my mind, that could happen pre-payment, is a fiscal emergency on the part of the government. According to Chapter 3 of TOM, where they have to hold funds for various branches of the service, is this program subject to those regulations, and could that happen?

MR. AKIN: This program is certainly subject to all the standard fiscal rules and regulations of the government. I don't know if that would result in a non-payment. It might result in a delay in payment.

Part of the funds for this program, as you saw from the CLIN structure, come from what we generically call the accrual fund, that fund that pays for the care, including prescriptions for the Medicare Dual Eligible. That is not subject to an annual appropriation. So that portion of it, I'm not concerned about.

The appropriated funds that will pay for coverage for TRICARE only eligibles, there is the potential of delay and

appropriation. If that happened on a long term basis, I don't know what we would do.

We have a ruling from the General Accounting Office that we are an entitlement program. At the same time we have many statutes that say we follow the appropriation rules and we cannot dispense funds that have not been appropriated and gone through the appropriate process to come to TMA.

So in the unlikely event that might have to get dealt with. But I think the most that would happen, as a practical matter, would be a brief delay in terms of reimbursement.

MR. SPILER: I'm Dave Spiler. Lt. Col. DeGroff, to follow up on the comments you made to my last question, my confusion came as a result of the definitions that are provided in Attachment 2. If I could just take a moment and ask you to clarify.

The definition of Avatrol sale price is that AWP is the wholesale list price of the drug, as listed in the Blue Book Essential Directory of Pharmaceuticals. Most discounting formulas use AWP as a reference point. DSCP and WebMDUs First data bank to obtain this information.

So if you could clarify when it comes to the financial evaluation and the true up at the end of each option year, which version that the government will use to evaluation the true cost of program delivery?

LTC. DeGROFF: Dave, if you wouldn't mind writing that question down on a piece of paper, and then what we'll do is go back and re-clarify that particular section in a formal written response.

MR. SPILER: Okay.

MR. MAYS: Any other questions on network reimbursements. Okay. Let's move on to talk about claims a little bit.

The Collector Retail Pharmacy Contractor will be responsible for processing all claims submitted within the geographic scope of the contract. This includes electronic media claims and paper claims.

We've got some standards down here that address claims processing time frames. The first one, 99 percent of electronic claims within five seconds; excludes PDTS.

What we mean by that is, we expect that you'd process a claim in your own system internally within five seconds. It does not include the time it goes out to PDTS for the DEERS eligibility check, for the CDCF update, or for the OHI check. This is the only one that's in your system.

We state 100 percent of EMC within five working days. Why the difference, five seconds to five days? That's to complete any prior authorizations that may be hung up in your system, or medical necessity reviews.

And then we've got the standards there for the paper claims. On the paper claims, all those will come in on a DD2642. That form will be available on the TMA web site so you can link to it. Beneficiaries will be allowed to fill that form out online, and then print it out so they may mail it to you.

We're also going to ask that you have these forms available in case a beneficiary calls you up, requests a form, and you can send it out to them.

Another thing we wanted to talk about claims, if there's an erroneous payment, we're going to ask that you recoup that payment. In most cases from the beneficiary, unless it's something that needs to be collected from the pharmacy.

In Section J, Attachment 3, we go into great detail about the recoupment process and the time frames involved in that. That's a broad overview of the claims process. Are there any questions about that?

MS. THOMAS: Just a quick question. Susan Thomas from Health Management Systems. We typically provide services to recoup erroneous payments where other health insurance is later identified. Rather than recouping from the beneficiary or the provider, we bill to whoever should have been the primary payer, and recoup the funds. Would that be acceptable?

MR. MAYS: I think we'd like to consider that in a little bit more detail, so if you could put that on one of the cards, and we'll address that on the web.

MS. THOMAS: Oh, certainly.

MR. MAYS: Thank you. Yes.

MR. HUDSON: Bill Hudson from Humana. This is actually a reimbursement question. Again, following up on the question by Mr. Spiler with regard to the AWP discount, and that CALC at the end of the year. Will the AWP that's submitted at the time of the point of sale be the basis of that CALC at the end of the year true-out, or is there another process, perhaps?

LTC. DeGROFF: PDTS will log the AWP at the time the claim is submitted from the retail pharmacy to the government. So we do log that AWP, and that's the one that we would use in the calculation.

MR. HUDSON: And that would be from the PDTS's first data bank, AWP data base?

LTC. DeGROFF: That's correct.

MR. HUDSON: Okay. Thank you.

MS. MANKA: Ilene Manka from WPS. I'm just questioning here what date you're using as a process date. Is it the process to completion date that's used in TED? If so, that's the date per TOM, that the check has to be -- whatever

has to be ready for mailing?

MR. MAYS: Don, you want to address that?

MR. KALIL: I think where I'm having a problem understanding is, what is your definition of date to completion?

MS. MANKA: Date to completion is defined in the TOM Manual. And there it's defined as the date that the claim has been prepared for mailing, or the reimbursement has been prepared for mailing. That's how it's defined in the TOM.

MR. KALIL: The date for submission on the TED is the date in which the pharmacy processes the prescription at the retail level. So that is the date that has been reduced into the TED as the date of service. And that's the correct terminology.

MS. MANKA: But then here, to measure this standard, what date are you using?

FEMALE VOICE: Can you ask her to submit that in writing because I think there is some confusion what is the process to completion date to TMOP and what will be the process to completion to retail?

MR. KALIL: And I think the real important thing here is this standard on a claim is not a TED standard. It's the prescription standard and when the prescription has to be processed from the pharmacy. This has nothing to do with the

TED submission.

MS. MANKA: But what date will you use to measure this standard?

MR. KALIL: The date the prescription was processed at the retail pharmacy. I think I understand where your question is coming from, and it would be very difficult to sit and explain that right here, and I think it's better done by presenting that in a question form, and having a formal written response, so that an example can be given.

MR. MAYS: Finding a few things to clarify here. That's good. Any other questions. How about a break. Take about 15 minutes and come back.

[Break taken.]

MR. KALIL: Any questions from the previous session that you thought about during the break that you would like to ask?

COL. DAVIES: The question that was from the floor regarding recoupment, not to the beneficiary but to OHI, we did have a little sidebar on that. We'd still like that in writing so that we can provide that on the web. But we see no reason to preclude that from occurring. As a matter of fact, that is a good thing, and that way we're not going directly to the beneficiary, but going to the OHI.

You'll also notice in the RFP that once the NCPD

versions support coordinated billing, and that becomes a standard in the industry, then we would anticipate that would be one mechanism that could be used, in order to execute that.

But in regards to your question regarding do you have to go to the beneficiary, can you go the their OHI, we feel that yes, you can go to their OHI for the recoupment.

FEMALE VOICE: We are the test company for that.

MR. KALIL: Anything else? Okay.

LTC. DeGROFF: There was one question asked of me during the break, and that was about usual and customary pricing, when you figured out your retail network reimbursement. And I would think that you would -- that's part of your network agreements with your retail pharmacies and you would have to make your own decision on how you were going to include usual and customary versus the AWP discount in your overall mix on your bid.

MR. MAYS: Anybody come up with any other questions on the break that they'd like to ask about anything we've talked about so far this morning? Okay.

We understand there was a little confusion about that last slide about claims and the title there, and we got a question about that in writing that we will address and post on the web that I think will clarify that.

Moving on, let's talk about prior authorizations.

Contractor will perform all prior authorization review for all covered pharmaceuticals. To see what's currently required to have prior authorization review by the government, you can go to the PDP web site, which is listed in the RFP, and it lists what drugs we require authorization for.

For these drugs, the government sets a criteria. On some of these drugs, we may go out and ask the contractor if they have criteria already developed, look at that review, and potentially use that.

PDTS maintains a prior authorization record. Once we get a prior authorization request and prior authorization is approved, that will be flagged on PDTS so it won't have to be done again in the future.

Also, it comes in from the TMOP. If there's a prior authorization granted under TMOP, that will be filed on PDTS so that you won't have to do it, if a beneficiary comes in to you with a prior authorization covered drug.

Also from the direct care side, if a prior authorization is issued there, that will be flagged on PDTS. So there are three different areas where prior authorization data can be entered onto PDTS.

And we've also listed the standards there for conducting the prior authorization reviews. Does anybody have any questions on prior authorization on what we've got in the

RFP? Sure.

LTC DeGROFF: I'd just like to clarify one point that Gene made. The prior authorization is captured at PDTS, which means that it's portable. So that would mean that if you received a new prescription for a required prior auth drug, you would submit it first, before you performed the prior auth, to make sure the prior authorization had not been done at another point of service.

COL. DAVIES: Gene, let's go ahead and show the medical necessity slide since the two are very similar to one another, but very different. That way we can avoid any confusion between the two.

MR. MAYS: Okay. Next slide. Medical necessity. Again, we're required, and primarily what we're going to be looking at there is if a beneficiary comes in requesting a non-formulary drug, to be provided with the same co-pay as a formulary drug. The standards are there. Fairly straightforward process.

Any questions, or Bill or Dan, would you like to address that a little further.

COL. DAN REMUND: I think it's important to note that things are going to change under the uniform formulary. A drug that is classified as non-formulary, under the uniform formulary, simply means that it's in the 3rd tier, or high

tier co-pay.

Right now under the proposed rule, for example, that's a $22.00 co-pay. Brand drugs on formulary, at the $9.00 co-pay.

So the medical necessity that we're talking about here is a circumstance where a patient has a medical necessity to use a non-formulary drug, in lieu of a formulary drug, and this determination simply affects the co-pay that is charged to the patient.

The patient can still obtain the drug, a non-formulary drug, in the absence of a medical necessity determination, for the $22.00 co-pay. So that's a different circumstance than what exists currently, because we don't have a uniform formulary in effect right now.

MR. MAYS: Now, there's one other item I'd like to point out with regard to medical necessity determinations. That's based on C-12 in the RFP, where we required that the determinations be completed by a member of the contractors staff.

You must be a physician, a pharmacist, a registered nurse or a physician's assistant. I want to make sure that everybody is aware of that requirement. So are there any questions on prior authorizations or medical necessity determinations?

MR. SANTULIS: Kevin Santulis from WPS. I'm trying to understand the logic behind having the medical necessity and prior authorization date reside on PDTS rather than in the contractor's system, since it's basically the contractor that's using it. Could you explain the logic behind that?

COL. DAVIES: The logic behind it is the fact that we have, in order to avoid having a disparate benefit, where that prior authorization flag resides on a proprietary system of the contractor, we have other points of service within our benefit. We have our direct care system, our military benefit treatment facilities. We have our mail order pharmacy program, and our retail benefit, which is what we're here to discuss today.

By having it reside at the PDTS level, we have a fully portable, prior authorization process. Today what happens is, if they went into the retail benefit and the prior authorization was approved, and then decided to use the mail order pharmacy program, it encumbered the beneficiary to then have to submit this requirement all over, again.

And this was pointed out within the GAO study that we needed to have a more uniform benefit. And therefore, by moving it to the PDTS platform, it's more uniform.

MR. MAYS: Any other questions on this.

MR. RUSHTON: Ron Rushton, PGBA. Two questions: the

first question is, I understand the prior authorization is a transaction that goes from the contractor to PDTS. Is that transaction in the NCPDP format record, or is there some other format methodology for transmission on that?

LTD. DeGROFF: It is an NCPDP type format. It can be done either in an online transaction, but in most cases, it will be done through a proprietary format in what's called Select Rx, with a prior authorization screen capability, that will reside at the contractor's site.

So you will have the ability at the contractor level to enter a prior authorization using the proprietary Select Rx.

MR. RUSHTON: Okay. So rather than having it be a physical -- I'm sorry. I'm a technical guy. I'm trying to understand technically how this works.

So rather than having a transaction that the contractor was saying through PDTS there's going to be another system you guys are going to supply us with, we're going to key the information in there, and that will get it on PDTS?

LTC. DeGROFF: In short, to answer your question, yes. But to walk you through the steps real quickly, you would submit that prescription to PDTS first. PDTS would then determine, in an NCPDP format, yes or no. You either get a paid claims transaction, or you'll get back an NCPDP rejection code, that will tell you to submit a prior authorization, at

which point you would then do the prior authorization and use Select Rx to enter the prior authorization, which would then be logged at WebMD on the PDTS data base.

MR. RUSHTON: Thank you very much. That's most helpful. The second question I have is the medical necessity. That's a transaction -- that's a claim by claim basis, is that right? I mean, there's nothing stored anywhere on that?

LTC. DeGROFF: Under the medical necessity, some of the processes would work exactly the same. If it was medically necessary to get that non-formulary drug, PDTS would -- and for lack of a better word, I'll say "set a flag," and then any subsequent claims that came for that beneficiary for that non-formulary, the co-pay would be returned at the $9.00 level.

MR. RUSHTON: Thank you very much. That's most helpful.

MR. HUDSON: Bill Hudson, Humana. I have a question about prior authorization as it relates to information in the ICD document. In there it speaks to accepting professional provider service codes, PPS codes, that will override prior auth requirements. I guess I wanted to understand, is that the intention that we would allow pharmacies to submit claims electronically with PPS codes that might then override the prauth, edit in the medi-select?

LTC. DeGROFF: Bill, that interface control document

is applicable to the contractor and not to the pharmacy. So that requirement or capability would be at the contractor level, not at the retail pharmacy level.

MR. HUDSON: Therefore, if I were to deem a prior auth acceptable or approved, I would submit the PPS code, which would then allow it to go forward. But we would not accept it necessarily from the pharmacy?

LTC. DeGROFF: Absolutely correct.

MR. HUDSON: Thank you for clarification.

MR. FRANCIS: Bill Francis from MedImpact. This may be out of turn at this part of the meeting, and you can just defer it to later, if you'd rather.

Am I to understand that the mail order component of this, and the retail are not going to go through the same system? That they're not going to be integrated?

LTC. DeGROFF: The mail order, the direct care system, and this new TRRx, will all go through the same basic platform of PDTS. In order to have the claim submitted for perspective drug utilization review.

MR. FRANCIS: Okay. So that component will communicate to us that there's a drug interaction, to communicate to the pharmacy network that's trying to fill a prescription?

LTC. DeGROFF: That is correct.

MR. MAYS: Anyone else?

LTC. DeGROFF: Let me -- I saw a couple of faces that maybe would not understand that. All perspective drug utilization review will be done on the central data base at PDTS. And those responses will be sent back through the contractor back to the retail pharmacy in NCPD format.

MR. HUDSON: Was your last comment then to mean that Pro DUR should not occur within TRRx. That all Pro DUR will occur at the MediSelect level? Or will the Pro DUR at MediSelect only be for outside of the TRRx network?

LTC. DeGROFF: To clarify that today in the managed care support contractors world, you do what's called "Host DUR." Outside of Host DUR is done by PDTS, meaning that all other points of service DURs are reported back to you, but you do within your own host cycle for your regions that you adjudicate claims for.

That will change under TRRx. Under TRRx all prospective DUR will be done at PDTS.

MR. MAYS: Anyone else? Don't let us off easy now.

MR. RUSHTON: I'm sorry. I want to make sure I have this flow-down straight. This is Ron Rushton from PGBA.

We would get on the SelectRx system, put in the prior authorization. Okay? Then we would submit the claim to PDTS. It would use the prior authorization that is on PDTS, to let

that claim pass on through.

LTC. DeGROFF: That's absolutely correct.

MR. RUSHTON: Then the question I have, inside the ICD, in the PDTS document, there is some section on authorization about overriding certain flags. Are we to set something that says we think this has a prior auth or is that an automatic process?

LTC. DeGROFF: No. Setting a prior authorization happens when you use the Select Rx process, and the screening logs a prior auth number on the data base, and therefore will allow all subsequent claims for that beneficiary on that particular drug to go through PDTS, either at that $9.00 co-pay or allow you to have that drug itself, because it's one of the benefit design.

I think some of your questions are more directed toward plan implementation. And once you sit down after award, and start taking your proprietary system that you are using, and integrating it into the PDTS process -- and those are kinds of things that you work through the plan implementation. I think that would be the same as you would be changing PBMs in retails worlds today, with the plan.

MR. RUSHTON: Okay. Thank you.

MR. MAYS: Okay. Going once, going twice. Let's move on to the next slide, then, which is marketing and

education. There's a couple of different aspects of marketing and education we want to talk about, and one of them having to deal with an initial mailing to active users of the retail pharmacy. We'll talk about this in a few minutes under the Phase In slide.

Right now what we want to talk about is marketing education activities on an ongoing basis to the life of the contract. To do that, one of the first things you'll have to do during the phase-in period, is set up an memorandum of understanding with the Communications and Customer Service Directorate within TMA, as to number and frequency of updates that you'll provide.

Now these updates will generally be on a monthly basis to the managed care support contractors, either the existing ones or the new ones under the new TNEX. They'll address such things as pharmacy network changes, educational materials, anything else that might be of interest. Maybe there's a new drug that's come out that's on the formulary or something, we want to publicize; things like that to be put into the monthly updates.

We also want to address distribution points and quantities, marketing brochures and the information card. Will you put a supply of those someplace? How many distribution points will you set up with CNCS, or internally?

We want to make sure that we can cover our total eligible population, being roughly 8.7 million beneficiaries. We want to be able to support them with marketing brochures and the information cards that we specified in the RFP. Any questions on any of that, on how that process will work?

MR. SPILER: Dave Spiler from MedCo Health. It's obviously a topic we're very familiar with, but understanding the financial incentive that resides on behalf of the DoD in the migration of prescriptions from the retail TRRx to the TMOP, can you discuss any current planned requirements or thought around how you might work with both vendors to consider strategies to migrate prescriptions from retail to mail?

COL. DAVIES: Dave, that's an excellent question. And unfortunately it would be conjecture on my part to sit here and propose how we would work through that. I would suffice that to say that once we have all of our contracts in place, then it provides us with that type of an opportunity to learn how to basically maximize the benefit, both for the government and for our beneficiary population.

MR. SPILER: As a follow up to that, would the government consider, either as an amendment to this solicitation or as a future modification to the TRRx, and maybe conjecture you can say it is -- a potential in the future for some type of incentive or program. Let me take

the financial piece of it. Would there be consideration for a program in the future that would address that opportunity?

COL. DAVIES: Once again, Dave, I think it would be conjecture at this point. But suffice it to say that once our contracts are in place, I think there is opportunity to sit down and at least be able to entertain that type of issue.

MR. HUDSON: Bill Hudson. I had a follow along to Dave's question. It's my understanding, then, that there would be some effort likely in the future to recruit business from the TRRx to the TMOP.

Understand that certain drugs have a higher margin than other drugs. To the extent that certain high margin drugs were recruited from one channel to the other, it could impact the aggregate discount value that you would submit on your proposal. Would there be some mitigation to that? Should these high margin drugs be recruited out of the TRRx?

COL. DAVIES: Bill, that's an excellent question, but it's all theoretical. I think you'll have to look at that as being difficult to sit here with a crystal ball and say this is what we'd try and do to move specific drugs, et cetera.

What we've tried to do in the proposal is provide you with enough data of our current utilization processes, and so forth, to be able to provide and submit a proposal of desire.

MR. KALIL: I would just add to that. If that type

of situation did arise, there are remedies within the contract for the contract that would bring those forward.

MR. SPILER: Dave Spiler, again. As Bill and I play serve and volley here, this is a specific question. Can the government provide potential bidders for the TRRx with the specific communication tools that the TMOP is currently using? And the places where they're using those communication tools to drive and motivate use of mail, because I believe that might be helpful in consideration of how we see the natural migration of retail to mail utilization.

COL. DAVIES: Except for the general marketing that we have done, there's really not a specific program in place to try and drive that market share. That is always the purview of the government to go forward with something like that.

But at this point in time, it's basically been marketing and trying to make sure the beneficiaries understand the benefit, and the coverage opportunities. So from a marketing perspective, we've done direct mailings to the current users or the previous users of the National Mail Order Pharmacy Program.

We've provided marketing brochures in bulk to the TRICARE Service Centers. We've provided marketing material to the direct care system, the MTFs.

We also, through any media type articles or whatever,

informed the beneficiary that the mail order program is a more cost effective venue for them from a cost share or co-pay perspective.

I think those of you in industry can look at your current books of business. You can look at our book of business as to what the percentages are, as to what is in mail and what is in retail.

I think if you look at our projections, which is part of the RFP, then I think that gives you the necessary data to understand what we're looking at occurring in the future.

MR. SPILER: Okay. Thank you.

LTC. DeGROFF: If you don't mind, Dave, I'll just add something before you ask your next question. What you may be referring to, or have heard about, was a project that was being done at the customer service center for PDTS in San Antonio where we did a pilot project to see how successful we could be in moving market share from retail to mail, with our current beneficiaries.

That project is no longer going on. It was extremely successful, but I did not have enough employees that were looking for work to do, since we're now responsible for the TMOP, and we sort of put that by the wayside.

We have not discussed formally, nor have we talked in any length or detail about a program going forward under the

TMOP to move retail to mail, at the present time. So Col. Davies is absolutely correct. What is there are the general marketing materials that have been sent out.

MR. SPILER: My last follow up is, given that the project team is the same for both the TMOP or the TRRx, will there be either a formal or informal communication process between the vendors when there are specific changes to a particular program, so that in essence both programs are kept in the loop as to changes that may affect the program?

MR. KALIL: That's what we want to have happen, and that's why one of the requirements in the contract is to establish an MOU with existing contractors.

MR. MAYS: Very good. Any other questions? All right. Let's go on to a brief discussion of management.

A couple of areas we want to discuss here in management. You can see that the management evaluation process has been broken into a couple different areas.

Part of it is going to be your oral presentation, which we'll discuss in some detail a little later. Part of it will be in the written proposal that you will submit.

In the oral presentation, what we are looking for is a description of your contract management plan. How are you going to manage a contract, what personnel you will be using, what's the experience of those personnel, how will you interact

with the government.

What the government is looking for here, basically, is a partnership with you to make sure that this works smoothly and do the best job we can to the beneficiaries. So we're looking for smooth interaction here.

As far as the management plans go, both the quality assurance plan and the disaster recovery plan will be part of your written proposal. In the quality assurance plan, we're very interested in how you detect problems, how you resolve problems, you have a continuing improvement process in place.

Disaster recovery, that's key to us. Thing happen, and we want to know how you're going to pick up the pieces if your main processing center goes down for a period of time, what's your backup plan. Any questions on that? Okay. Let's move onto the next slide then.

Beneficiary services.

MR. SANTULIS: Sorry, I didn't realize you were done with management that quickly. The question I have is not actually on your slides.

In the RFP, the section following Quality Assurance Plan, is Fraud and Abuse Protection. I did have a question related to that.

In today's environment, especially in the pharmacy world, where we're looking at potential beneficiary fraud, one

of the things we're really looking at is beneficiaries with drug seeking behavior. And now that these contracts between the managed care support contractors, and they'll be processing claims for hospital dispensed drugs in emergency rooms, and also doctor dispensed drugs, compared to the retail pharmacy which will be dealing with the other side of it, does the government have a plan to coordinate that, or is that up to the contractor to try to find a way coordinate that MOUs with the MSC contractors?

COL. DAVIES: We're currently doing that today, believe it or not. There's a provision, and I can't -- one of my colleagues out there may know in which manual it is and what section it is -- 14-something.

MR. KALIL: Actually, we have Rose over here from Program Integrity.

MS. SABO: Good morning. In the chapter on fraud and abuse, if a beneficiary has drug-seeking behavior, it's best to make arrangements with the managed care support contractors and they can work with the doctor and make sure a single provider is designated, through which all the medications are obtained, and single pharmacy is designated, and there is some control.

It's important for the patient to be encourage to seek drug rehabilitation. We don't really want those cases

referred to as if they're fraud cases. We want those people to take advantage of the very generous rehabilitation program that we have for substance abusers.

COL. DAVIES: And to piggy-back on what Rose said, we currently have a process that we can communicate between the disparate points of service and be able to flag and block that within PDTS, in order to be able to avoid or preclude a beneficiary from obtaining controlled substances if that's the issue, from another point of service.

In the past, under a disparate benefit, it was very likely that a beneficiary could use multiple points of service and therefore not be identified as a potential candidate to be routed into the health care arena for their condition.

MR. SANTULIS: So I'm interpreting this to mean that the retail pharmacy contractor then would have, from their perspective and what they're going to be seeing, they would probably have minimal involvement in terms of initiating an investigation. That would probably come from TMA, then, based on what they're seeing as collected data?

MS. SABO: There should be controls in place in your system, through the artificial intelligence system you have, or through your data system, where you can identify someone who is excessively using controlled substances. It should be part of your plan to identify those cases. Of course much of the work

would probably be done by other sources, like the managed care support contractors.

The system that Col. Davies just explained, the PDTS system, to give you an example of how successful this is, we had a case -- most of you probably know about the State of Florida versus Graves. This was a case in which a doctor had been indicted for manslaughter charges for four patients that had died, for indiscriminate prescription of oxycontin and other controlled substances.

The judge said, "You can stay out. You don't have to be in jail till the trial starts, but you're not allowed to prescribe any more of these controlled substances." Well, he thought, "Oh, we'll use the military health care system hospital pharmacy. They'll never catch us that way. They're just looking at the retail pharmacies."

Well, he was caught, and as soon as the judge found out about it, he was put in jail.

MR. KALIL: Thanks for the explanation, Rose. Go get the bad guys.

MR. MAYS: Thanks, Kevin. Please don't feel afraid to backtrack on me if I move too fast. Anyone else? Okay. Beneficiary Services.

A few things we wanted to cover here. The first one is the web site. We're looking for a dedicated page from your

web site that will let the beneficiary learn about the TRICARE Retail Pharmacy Program.

Some of the things that should be on that page are the benefit itself, what's included, things like beneficiary service center phone numbers, hours of operation for the service center for the beneficiaries, mail and e-mail addresses. Other ways for the beneficiary to contact you.

One of the things that we're particularly interested in are formulary alternatives to non-formulary drugs. So if a beneficiary has been prescribed a non-formulary drug, they can go to your web site and find out what some of the alternatives are.

Of course, we have the basic things, like links to the TAM Pharmacy Web site. Web sites of the TMOP, and the other managed care support contractors.

We want the beneficiaries to be able to locate a network pharmacy within their zip code. They'll be able to put in their zip codes and be able to find what the closest pharmacies are.

Also the prior authorization forms. View those and download them so they can have those easily available to them.

We have a requirement in there for toll-free telephone service throughout the geographic scope of the contract. It specified some minimum operating hours.

One of the things we have in there is about the automated response unit. When a beneficiary calls in, they should immediately be able to select to speak with a live customer service representative, rather than listening to a long menu list before having that option. That's all in the interest of beneficiary service.

Now you may have noticed that in the standards that we've got the customer service, beneficiary service. We don't have a lot of standards. They're very sparse.

We did that intentionally to allow you the opportunity to give us your commercial standards. And that will be evaluated as part of the best value determination. So I would encourage you to come up with the best standards you feel you can support. That applies to both telephonic standards and the written inquiry standards. Any questions on any of that? I guess that part was pretty clear. Next slide, please.

All right. Next we will talk about the pharmacy data transaction service and the TRICARE encounter data records.

Connectivity to PDTS, or the Pharmacy Data Transaction Service, is described in the retail pharmacy ICD, interfaced controlled document, which may be found at Section J, attachment 4. Sounds like most of you have already found that and have read it thoroughly.

The connection to PDTS will be by a government provided communication line. We'll provide that and maintain it.

A couple of key points here that you'll be interested in, because it deals with payment. If the PDTS generates the TED record, based on your data, based on the data the contract provides to PDTS, PDTS will take that data, format it into the TED record, and then submit it into the TMA.

There's two elements of payment there. The first one is payment to you, the contractor, which is based entirely on the TED records. When the TED records come in and are approved by TMA, passing all the edits, that will generate payment to you of your claim rate of ten cents, twenty cents, whatever that may happen to be.

It's very key that the data entry and the timeliness be met. If there's any invalid data elements, it will cause those TED records to kick back and will delay payment to you, the contractor. So it's critical that those be accurate.

The other part of that is payment to the pharmacies. That's also keyed off the TED records.

It's a little faster than what will happen with payment to you, the contractor, because as the TED records come in, they come in on a voucher record, and so long as that header record passes the initial edit when it comes into TMA,

you'll be authorized to disburse payments to the pharmacies on whatever cycle we agree to with you on a post toward basis.

Just to backtrack to the one about payment to you, the contractor, that will normally follow about twenty days after the TED is submitted. So after the first twenty days of the contract, when you start submitting TEDs you'll be receiving TED payments on a daily basis on the transaction. Any questions on any of that?

MR. HUDSON: Bill Hudson from Humana. With regard to the TED provider records that's reference in C.14.4. My question is, will the NCPDP number of the pharmacy be the central identifying number for that provider, or is there a crosswalk within the TEDs engine that takes the NCPDP number and creates something else? I guess my concern would be if that crosswalk could lead to a lot discounts.

LTC. DeGROFF: No, that NCPDP number is the driving number all the way through the system.

MR. HUDSON: Okay. With regard to the validity edits that will occur, will it be possible for us to understand those such that we might set up a edit on the front end to assure that only accurate data gets into the transaction, rather than remaining something within TMA and we would not fully understand it.

LTC. DeGROFF: I think one of the things you'll

notice, Bill, when you review the interface control document for this is that there are many more required data element fields than there were in the previous contracts.

The reasons for those required data elements is because of the TED. If those elements are sent to PDTS in either inaccurate format or blank, that claim will be rejected back to you immediately.

We do not want to get involved in the process of having to re-do TEDs after they've been submitted. So in fact, without an accurate submission, there would be no paid claims response.

MR. HUDSON: One last question to do with TEDs, and this has to do with paper claims that are submitted, that are keyed into PDTS, often on the DoD 2641 form, or perhaps on a receipt that a person may include with that submission, there's not really the level of detail that's needed to fulfill that NCPDP transaction, and I assume, the downstream TED requirements. Do you have any thoughts how that may be overcome?

LTC. DeGROFF: Bill, I think you'll find, and we're probably going to have to take that as a clarification question, just to get some more detail back to you, but I think you will find that the majority of what is required to populate a TED will be on some sort of claim coming from the beneficiary

so that you can enter it into a field.

There are certain data elements that while they may be required, could be reformatted, so to speak, so that the requirement is met.

One of the things to understand what PDTS does, it takes what you submit, but then it matches it with probably another 43 data elements that we receive off of a demographic eligibility record that we get from DEERS and DMDC. So it's not just what we receive from you that populates a TED document that goes forward.

MR. HUDSON: I understand. But for example, day supplies often is not on a receipt or is not requested on the DoD form. So that would be an example of one that could potentially create a disconnect.

LTC. DeGROFF: And I understand that. We would do at plan implementation after award, and decide what would be populated within that field. If you want to throw a day's supply, I would think what you would do is probably just reside to a 30-day supply as a default, but we would work that out during plan design.

MR. HUDSON: Thank you.

MR. McKAY: Bob McKay from Pharmacare. Two simple questions, I hope. Is the claim that we sent you, through our system from the pharmacy, the claim by which you prepare the

TED, or do we have to send an additional batch file, for example?

LTC. DeGROFF: No. The TEDs will be automatically produced on a daily basis after the whole period based on that pharmacy claims transaction that comes into PDTS.

MR. McKAY: Thank you.

LTC. DeGROFF: And just to add on, you will be provided back a record, probably in the batch format, but again, planned design on the end of what is submitted for payment.

MR. McKAY: Thank you. With respect to payment authorization to pharmacies, going back to my original question earlier about risks associated with payment to pharmacies, you mentioned 43 data elements that might be referenced from the DEERS systems, and other systems, that are appended to that record that we submit, that helped create the TED.

That represents something that is outside our control, for example. So when we submit a claim, comes through, and there's this post adjudication activity in the creation of a TED, that TED creation could fail, but the pharmacy has already dispensed that drug, and I have incurred a liability to pay that pharmacy. Could you address that?

LTC. DeGROFF: I think the key here is, eligibility drives the payment of the claim. The other data elements that

we receive from DEERS are purely administrative type data elements, and they're used for financial and administrative purposes, to decide how the money is allocated. Maybe Carl would want to elaborate on that. But I think in a nutshell that's what happens here. It doesn't have anything to do with eligibility and whether or not the claim is going to be paid.

MR. AKIN: I don't have anything to add to that. I think the payment -- the TED record, while it keys whether or not we release the funds for you to pay the pharmacy, creation of the TED is really a collaborative effort between the PBM and PDTS. If the problem resides within PDTS, then Col. DeGroff already knows that we can beat on him, rather than beat on you.

MR. McKAY: Again, just to reiterate our concern. The claim that comes in from the pharmacy, if it passes the eligibility component, the pharmacy will dispense that drug, the liability will be incurred, payment from me to that pharmacy is anticipated.

During the post process that TED has created, the TED could fail for some validity edit or some other edit or activity associated with other elements that are not under my control. Is it the case where I may not get payment for that drug? Is it a case where I'm going to have to tell the pharmacy that they dispensed a drug that I can't pay you for it. I'm waiting for the re-completion of a complete TED.

MR. AKIN: If the completed TED, okay, that comes in a set of vouchers and has already gone through all the pre-editing, I'm going to call it, that is done at PDTS, matches what we need on the daily submission on what we call the header record level, then we will be releasing funds for you to pay to the pharmacy, either on a daily basis or on some other periodic basis as specified in Section G.

If in that detailed TED, the individual record fails, you will -- we will go back to PDTS, and if the problem that caused the failure is something that happened to PDTS, they will be expected to clean it up. If it's a missing or transposed something at your level, they will be coming back to you. There are specified times in which you have to make the correction and get the TED record corrected.

If you don't meet those time frames, we will then be coming back to you and saying, "We are recovering the funds from you, the prime contractor, whether you recover them from the pharmacy or not. We are recovering both the administrative payment that we've made to you, if that's what happened, and the payment that you made to the pharmacy."

There's a different amount of time there given to PDTS and the PBM to interact with the pharmacy or the beneficiary, or whatever is necessary, in order to make any corrections to the TED, if the individual record fails.

If the PDTS pre-editing process works as smoothly as we anticipate, they will never have submitted a TED. They will have bounced it back to you immediately.

We won't see that in the header record, we won't have released the funds. At that time, the issue becomes one between you and the pharmacy or you and the PDTS.

Again, I think going back to what we said earlier, assuming you have received a positive eligibility response, prior authorization, medical necessity determinations aside, there should be no instance of you being on the hook to pay the pharmacy without us making those funds available.

MR. McKAY: Thank you. I'd like to ask about one scenario that could happen, where you did get a successful eligibility lead back from PDTS and the TED was created, pharmacy was paid.

After the fact, maybe long after the fact, it's discovered the beneficiary had OHI. Would all the claims that the beneficiary got during the ensuing period be subject to recruitment?

MR. AKIN: They would be, assuming the OHI was in effect during that entire period that it included a pharmacy benefit. We would come back to you and say, "You owe us for these claims." The ultimate liability is that of the beneficiary or to whomever you made the payment.

If you made the payment to a pharmacy the pharmacy owes the money back. If the payment went to a beneficiary, paper submitted claims, which we hope will be very few, except for those that already are saying they have OHI, then it would belong to the beneficiary.

If you chose, I think we discussed earlier, to go after the OHI directly, rather than going back to XYZ Pharmacy chain, that would be perfectly acceptable as to how you recovered the money.

MR. McKAY: So of the choice of these two, we discover one of the OHI situations, you're going to come to the contractor and just take all the disputed money back, and it's on our --

MR. AKIN: No. There are specified in whatever attachment that was referred to earlier, the recovery processes, the time frames, et cetera, if you'll look at that, that will tell you the process to follow the time frames.

If ultimately, let's say, the money was paid to K-Mart, who's in bankruptcy, okay? If there's bankruptcy of a pharmacy chain, for example, there's all sorts of provisions within our General Counsel's Office, there are recoupment specialists, including attorneys who specialize in dealing with these situations.

Unfortunately, we've dealt with it before. There's a

whole set of processes there. If K-Mart has discharged its debt to XYZ PBM, that will be dealt with in accord with the way the attorneys in the recoupment, the bankruptcy proceedings, et cetera, proceed.

But we don't come and take the money directly from you. We expect you to write demand letters. We give you all sorts of information about what the demand letters should say.

There's a provision for that. They come into TMAs office, this recoupment section. They have certain demand letters, so that we can attach your tax refund, and do various other things to recover the funds.

I think all of the detail on the recoupment process is in the attachment.

MR. McKAY: Thanks.

MR. SEAMAN: These are government dollars that are being paid. The debt is owed to the government.

Unless you as the contractor have done something that basically you shouldn't have done, the ultimate liability is going to fall on the person who committed this. There are processes by which we can in fact recover money from you, if in fact the payment was made as the result of some error or failure to follow the premise of the contract.

But obviously, if someone fails to report OHI, and you follow the rules, and we find out that it was an OHI or

that somebody got the proceeds from the OHI and didn't come back to DoD, that's ultimately a claim by the government against the individuals.

You will initiate the recoupment force at the initial stages and try to recover that. To the extent you can't, it will come into my office, and we'll pursue it.

MR. SANTULIS: This is Kevin Santulis from WPS, again. On the subject of OHI, when the opposite happens, when a beneficiary walks into a point of sale pharmacy and presents their prescription, but when the query goes to PDTS and comes back through DEERS saying they have OHI, which may have been posted by a managed care support contractor, or some other contractor beyond the retail pharmacy contractor's control, then that beneficiary says, "I don't have OHI for prescription drugs," how is the retail pharmacy contractor and their network to resolve that situation?

LTC. DeGROFF: We currently have a process in place that we're using today, where the beneficiary is only obligated to provide, let's say, an EOB or something, proof of no pharmacy coverage from their insurer, and then with that proof back to PDTS, actually to the Customer Service Support Center in San Antonio, the flag is removed from the PDTS data base, and all subsequent claims are allowed to process.

MR. SANTULIS: Based on subsequent actions to that,

by the managed care support contractor, could that flag be put back on, again?

LTC. DeGROFF: Yes, it can be put back on, again.

MR. SANTULIS: Thank you.

LTC. DeGROFF: Only if they have pharmacy coverage, I just want to make sure of that.

MS. SCATURRO: Hi, Liz Scaturro, MedCo Health. My question relates to the monthly electronic report request. You have it listed as a bank reconciliation report.

Basically the report is asking for the previous month's TED transactions. My understanding is that the contractor is responsible for providing the data elements for the TED record. PDTS is actually submitting them to TMA. So I was wondering if you could give us some clarifications around what exactly that report is going to contain? Sounds like you were asking us to report back to you. How many TEDS were submitted for the previous month.

MR. AKIN: What we're asking you to report back to us is your bank account, whether we're referring to the one for the dual eligibles or the TRICARE only eligibles, will show that the government has allowed you to pull out of the Treasury "X" million dollars that month, and dispense that to individuals to non-network pharmacies and certain network pharmacies whether it's a single check for several million

dollars for an entire nationwide chain, or regional chain, whatever.

We need to be able to track the dollars that you have dispensed from that government bank account, back to the individual TED records. The information that PDTS will be providing back to the contractor, to you, should enable you to tell us which sets -- and presumably when you pay XYZ chain, you told them which scripts you paid them for. You had an electronic remittance advice or something like that.

What we need is sufficient detail to know which ones of the prescriptions that are reported in PDTS, put into a TED format, and then sent to us, and then we authorize you to release money for, which ones we have paid for.

It's basically to make sure that the government funds don't go out the door twice for the same prescription. So I think that's something that could be worked out in terms of implementation so that there's a crosswalk between your remittance advice that has whatever set of numbers that you attach to the check, to the EFT that you submit to one of your providers, and we can cross route your electronic remittance advice information through PDTS to the associated TEDs and we can, that way, assure ourselves that the payments were done for this set of authorized TED records, and not for any duplicates or not for TEDs that were rejected.

MS. SCATURRO: Okay. So in clarity, you're asking us to actually keep track and report back to you on TED records that were approved; not report back to you TED transactions?

MR. AKIN: I'm confused by the term "TED transactions."

MS. SCATURRO: Section F.2.16. First sentence.

MR. AKIN: I would interpret F.16 to mean the individual TED records that were approved.

MS. SCATURRO: Approved. Okay. I have another question, actually back to beneficiary services, regarding the initial mailing request.

I realize there was an estimate of 40 million scripts previously dispensed for this population. However, the initial mailing only required users that used the program 12 months prior to the effective date. Do you have an estimated number of unique users for that time period?

COL. DAVIES: I believe that information is in L.6, if I'm not mistaken, and it was approximately 2.5 beneficiaries that have used the retail pharmacy benefit over the past 12 months.

MS. SCATURRO: Okay. One last question regarding appeals. Outside of the appeals process, that the contractor would be expected to support for medical necessity, as well as prior authorization, I do realize that the expectation of the

contractor should support an appeals process for all of the rest of the claims that fall outside of those two processes, related to CFR 199.

Can you elaborate a little bit on what level of appeals you would expect the contractor to support for that?

COL. DAVIES: Basically what we anticipate within the appeals arena, you have really three areas that you could potentially have appeals, at least three major areas. There's always a chance of an anomaly out there.

The first would be excluded drugs. One thing we didn't mention about non-formulary and the CFR that we currently provide our benefit under, there are medications that are totally excluded from our benefit. In other words, non formulary but non covered.

Occasionally you have appeals from a medical necessity perspective for a non-covered drug that usually is generated by the appeals process, because it's a denied claim.

The second arena would the prior authorization, where a prior auth was determined not to meet the prior authorization criteria, and denied.

The third one would potentially be a situation where the medical necessity review under the uniform formulary simply drives the co-pay from a $22 co-pay; third tier -- proposed $22 third-tier co-pay, down to the $9.00 co-pay, which would

probably be very few of those.

Their specific references to the statues or to the -- I don't want to mess all that up -- that we have in the RFP, that outline the processes that would take place in the initial appeal review, and then determination made by the contractor that is either approved or subsequently denied. Then the explanation of the beneficiaries additional appeal rights, in order to push that up to a higher level, that then is reviewed by our Pro-contractor that covers those appeals issues. And I'll defer any other clarification.

MS. SCATURRO: Thank you.

MR. LEONARD: My name is Michael Leonard with EHIM. Clarification on the government provided communication lines.

In the case of a geographic separate L-oversight, is the government providing the communication lines to both the primary and the secondary site?

LTC. DeGROFF: Yes.

MR. McKAY: Bob McKay from Pharmacare. Question regarding commercial practice and pharmacy reimbursements. We reimburse on a cycle basis, as you are probably aware. Different PBMs use different cycles.

We use two cycles a month. When the cycle, assume the cycle closes the 15th of the month, within ten days of that period we reimburse the pharmacy for the expenses incurred.

Based on what we heard today, I think, there could be a case where I may not be able to reimburse that pharmacy because I may not have received authorization yet for reimbursement for a series of claims associated with a certain date, based on a TED voucher. I haven't received authority or an approved voucher to go to the bank and get the money.

I also reimburse pharmacy in lump sum payments with remittance advices. Could you just speak to the way the industry runs -- and I know you do understand how the industry work, 'cause you've done some time with industry and spent some time with industry, versus how you're anticipating this would coalesce with the industry practice.

MR. MAYS: Let me say a couple things about that first. On a post-war basis, we will work with you on your payment cycle to determine how you want the payments made.

As a point of clarification, before the TED is submitted to TMA, there is a ten-day hold period to account for any reversal process. And then once the TED is submitted to TMA, so long as that header record vouchers that Carl described earlier, as long as that balances, within 24 hours you will have payment authorization for the pharmacies.

So I think we can support your payment cycles, unless there's a data error that causes that to reject.

MR. AKIN: I would simply add the point about

timeliness. Once the TED has cleared at the header level, which is we make available through a process that involves the Federal Reserve Bank and the U.S. Treasury funds that are available immediately.

It is all done on an electronic basis. There is no voucher that you have to take to the bank. The funds will be available for these specified bank accounts immediately, so that any EFT you send out, using that particular account number, will be honored by your bank, because they know they can draw those funds directly from the treasury.

The lump sum piece of it, I'm not familiar with. That's a separate issue that I guess would have to be worked out on implementation.

As Gene said, if you look at the RFP, bottom of page 19, section G1.1.4, it talks about accommodating a cycle time so that if you are a -- pay twice a month, once a week, whatever, or if you choose to pay your networks on a cycle, and the paper claims and non-network submissions that you get on a daily basis, as long as those come in separately, we can work that so the funds are available on a daily basis for paper claims, and twice a month for your major cycles. There will be the 10-day hold that you referred to at the PDTS level.

MR. KALIL: I don't want to stop any questions on this particular issue, but understand, too, that we have a

whole section coming up on the TEDs and payment process.

MR. McKAY: Thank you.

MS. MANKA: I'm Ilene from WPS. I'm not sure if my question should go to that section or not, so just tell me. I just kind of want to understand the sequence of events that happen.

The claims get submitted. And these are paper claims or electronic claims; they get submitted, they get adjudicated. There's a ten-day hold on all of them?

MR. AKIN: Let me interrupt you. I talked to Col. DeGroff about the term "adjudicated," so I'll work on the rest of the group.

The claim from a financial perspective is not adjudicated until it is accepted at TMA. The fact that you have processed it, that PDTS has processed it, is simply processing.

The adjudication occurs at our level when we accept it, and this has to do with appropriation law and a variety of other requirements of government funding that I won't bore you with.

The process, though, whether it will be on a paper claims, whether PDTS will place a ten-day hold, I'll leave to Col. DeGroff. But on the electronic submission, there is a ten-day period in which this pre-edit process will occur. We

are assuring ourselves that in fact the script is delivered, and are picked up by the beneficiary. Then that is submitted to TMA, and goes to the usual process that today you know with HCSRs in the future, and I know we just stared with TMOP for the TED record.

LTC. DeGROFF: We needed to determine some point of having our claims "put on hold" for ten days, so that we could account for all the reversals that would happen for the non-compliance within the retail networks.

When we talk to our industry experts and our consultants that were helping us through this process, it was discussed on what would be the correct number of days to put it on hold, and it was anywhere from ten to twenty.

We decided to go with the ten-day figure, feeling as though the majority of the claims would have already been reversed at the retail level. Therefore, if they were reversed, we wouldn't have to reproduce corrected TEDs and take payment away from cycles that were further out than they would from the daily cycles being processed.

MS. MANKA: But does that apply to a paper submitted claim?

LTC. DeGROFF: I would have to say yes, unfortunately, because the TEDs are all rolled up into one TED record. I mean, they're rolled up into a daily batch processing, so if

you submitted one based on today's date, it would be held for ten days. Of course, that one wouldn't be reversed at that point. There's no differentiation on a TED between a paper claim and an electronically submitted claim. Is that correct?

MR. AKIN: That is incorrect. If you'll note in the CLIN structure, there's a separate sub-CLIN for paper claims, versus electronical claims on the -- giving you the flexibility to charge differing rates on those claims.

LTC. DeGROFF: Sandy, you and I will need to talk after this.

MS. MANKA: Okay. So there will be a ten-day hold on papers and -- true? Okay. So after the ten-day hold, then, you go on the eleventh day and you prepare the voucher to be submitted to TMA.

And then in 24 hours, TMA has guaranteed that you will get a response back releasing moneys to cover those claims. True?

MR. AKIN: Correct.

MS. MANKA: The contractor, in the meantime, they have to collect the data to prepare the checks, okay? How is there an exchange of data to make sure that the exact same claim grouped into that voucher gets grouped into that pay run, so that the moneys are sure to match?

MR. AKIN: When PDTS submits the -- what you're

describing as the voucher on behalf of the contractor to TMA, they will be simultaneously submitting it to the contractor.

MS. MANKA: Okay. So when the money gets approved, that will be forwarded on to the contractor?

MR. AKIN: The approval will be.

MS. MANKA: Okay.

MR. AKIN: Remember, we're approving the release of government funds at the header level. This does not guarantee that every TED in that particular voucher is in fact going to pass all the edits.

We're approving the money that we're making available in these bank accounts from government funds, for you to pay the pharmacies at the header level. You will get that approval or disapproval of the entire voucher, if you will, at the header level within the 24 hour period.

MR. MANKA: Thank you.

MR. RUSHTON: Ron Rushton, PGBA. I just heard you say something that I hadn't heard before. I just wanted to make sure I got it straight.

At the same time that TEDs sends the voucher back to PDTS to say they are cleared, there's a transmission that will also come to the contractor. Did I hear that wrong?

MR. AKIN: TMA will not be responding to PDTS. Okay? TMA will be responding to XYZ Corporation saying that

this particular voucher, which was a group of claims, individual prescription claims that were grouped and put in TED format by PDTS is approved, and you can go through the banking process that I described earlier, and release those funds and use them to pay your pharmacies network, beneficiaries, whoever.

If we reject something at the header level, that will go back to PDTS. We will let PDTS know but our official response goes back to the contractor and not to PDTS, not through PDTS.

MR. RUSHTON: So the question I have is, when we receive that from TEDs, when TMA says, "We cleared this voucher. Everything's fine." Will we get back in that transmission the detailed TEDs also?

MR. AKIN: No. You will know from PDTS what detailed TEDs were submitted. We will not know until we run these all through the individual edit process, which comes after approval at the header, obviously, which ones might have failed.

What you will get back is a transmission through PDTS, that says the following 17 failed, or hopefully none failed.

MR. RUSHTON: Okay. What I'm trying to determine is, how I'm going to match up the TED voucher to the claims at

the end of the month, when I don't seem to know what the TED voucher is for those funds.

MR. AKIN: TED voucher, when PDTS creates it, will be given to the contractor, and will be submitted to us on behalf of the contractor; "us" being TMA, Contract Resource Management.

We will approve or disapprove at the header level, and if it fails at the header level, obviously you will know about it immediately. If there are individual TED records that fail, you will know about them later on in the process and have to get those corrected.

You will know from PDTS what they are submitting on your behalf. That's what you'll use to match at the end of the month.

MR. RUSHTON: Okay. So they're going to give me back the voucher number and "all clear" test?

MR. AKIN: They're going to give you back the voucher number and what they submitted in that voucher.

MR. RUSHTON: Thank you. That's perfect.

MR. AKIN: That's step one. If individual TEDs within that voucher fail 72 hours later, they will then come back and say, "Guess what? These failed. We need to get them corrected," with the appropriate error message, et cetera.

LTC. DeGROFF: And that appropriate error message

would be sent back to you whether it failed based on a PDTS problem or a contractor problem, because we'd want you to know that the payment for that particular claim was being held up.

MR. AKIN: No. The payment for the claim rate, if you will, for that particular claim may be held up. The dollars released for the benefit are already gone.

It is the admin fee that is potentially held up. The dollars that you owe the pharmacy or the beneficiary were released at the header level.

I referred earlier to the fact that there's a specified set of time that is several days, several weeks, that has to get that TED corrected, and assuming all the corrections are done, we wouldn't be coming back to you for the dollars that you paid from the government account, or for the admin fee that we might have released.

MR. RUSHTON: Okay. Great. Thanks. Another question then.

There seems to be, at a later point in time, some transmission from PDTS to the contractor of DEERs demographic data, and a turnaround where, within 24 hours, we send back the claims with bank account numbers on that. Is that the way that works? Got a separate transmission of some sort, or did I miss something?

LTC. DeGROFF: There's no transmission from PDTS to

the contractor on DEERs demographic data. The DEERs demographic data comes directly to PDTS.

MR. AKIN: We need to caucus on that, and come back to that.

MR. RUSHTON: Okay. Great. One more. TEPRV, before the contractor can submit claims, for a certain provider, we have to make sure that those get entered into TEPRV with the appropriate sub-identifier. So I'm assuming the contractor has some connection to the TED system to be able to do that. I just don't know how it's happening.

MR. AKIN: How is provider information submitted to PDTS? I can't answer the question on TEDs. Maybe you need to submit that in writing, Ron, if you will.

MR. KALIL: Sandy.

MS. JONES: Col. DeGroff is talking about submission of the provider records. Right now, all the contractors submit to the TMA their provider records, in order for the TED record to go out and make sure the provider is there, and everything is kosher with the provider.

What he is asking is, are the contractors still supposed to do that, or is that going to be done through PDTS? And Ron, I can't answer that, because I don't know. I have to ask Don, too.

LTC. DeGROFF: Sandy, I think we'll probably have to

sit and talk about that and get a clarification.

MS. JONES: I think that's an excellent idea.

COL. DAVIES: One of the confusions, too, is to the fact that a lot of folks are used to dealing with health care provider type records, versus the pharmacy type records. Sometimes the confusion of terms intermingling, and so we want to make sure we understand completely what the question is.

MS. JONES: That's another thing. Plus, these people are used to doing this all themselves. And PDTS is taking over the burden of a lot of that, and we're trying to figure out what they did before, and what they have to do now.

MR. MAYS: I think before we take any more questions, we'll take a 15-minute break and let everybody stretch your legs.

[Break taken.]

MR. KALIL: We do have another question that came up during the break, and again, I'll ask anyone if there were any side conversations, any questions that came up. If you have any, please come to a microphone and present them. Otherwise we can take them on a sheet of paper, as well.

This question is: "What is the obligation of PDTS to share data upon request from other contractors, including retail pharmacy TFL, when developing a case to protect drug seeking behavior or a fraud case?"

LTC. DeGROFF: PDTS has a responsibility to do that as part of the uniform benefits. And whether it's one contractor and has no relationship with the three managed care support contractors out there, that's not an issue. PDTS will help and provide information on a data use agreement that we will have in place with each one of the managed care support contractors.

MR. KALIL: Were there any other questions?

MS. HAYES: I'd like to backtrack to something you said earlier. I'm Earleen Hayes with Meridian Consulting.

In talking about the appeals process, you indicated that the next level of appeal would be the PRO. Could you elaborate on that, please?

MR. SEAMAN: When this program was set up by Congress specifically for our pharmacy program, they put in requirements that we had, expedited appeal process on medical necessity. So that's where our PRO process comes in.

Basically, the TRRx contractor will provide the initial review and the initial decision, but if somebody asks for an appeal of a medical necessity determination, our PRO process is set up so that will be an expedited appeal to them, so that they can get back with an answer immediately.

That's where the PRO process comes in. It's the only medical necessity issue that's going to be rising out of this

contract.

MS. HAYES: So that would be a function of the current, existing, expedited process to NQMC?

MR. SEAMAN: Yes.

MS. HAYES: Thank you.

MR. SPILER: Dave Spiler from MedCo Health. I'd also like to backtrack for a moment to the financial terms of the deal, which a question came up during our break.

In the frighteningly hypothetical situation, where the negative incentive applies, and the contractors obligation on the negative incentive is greater than the fees owed to the contractor by the government, is the contractor responsible for any amounts over and above the fees that they would have collected?

MR. KALIL: That's a true statement.

MR. SPILER: Thank you very much.

MR. MAYS: We're moving along pretty quickly here with this agenda, and we do have provisions in here for lunch. But if we're at that point where we make a determination, do we spend an extra hour and forgo lunch, how many would be in favor of that? Great. Thank you.

MR. MAYS: If there are any other questions on anything we've talked about so far, we'll go ahead and move on to the next slide which deals with phase-in.

As we've addressed already, the RFP does provide for a six-month phase in from the time of award, to the time we start delivering pharmaceutical services. Included in this six-month phase-in period, we'll do the DITSCAP approval to operate. We're looking for that to be in place at the time we start.

We discussed yesterday the potential for an interim approval to operate. Our preference is to get the full approval.

One of the other things we're looking at is connectivity to the PDTS, and certification that the activity is in place, and is fully supporting accurate transmittal of data from the contractor to PDTS.

We're looking at memorandums of understanding with communications and customer service director within TMA, as well as memorandums of understanding with other TRICARE contractors, the managed care contractors, the TMOP, the TDEFIC contractor, to support distribution of marketing materials to brochures, information cards, and the quantities involved.

Remember, we are looking to support the 8.7 million beneficiary population in the Health Care System.

Also in the phase-in period, is this initial mailing that goes out to the 2.5 million beneficiaries that are current users of the retail system, or have used it within the last 12

months preceding the mailing. That would be the marketing brochure, the description of the program, and the information card.

We have to have our reporting, so we've got some weekly reporting for the transition purposes, to tell us how things are going. Question?

MR. SANTULIS: Yes. This is Kevin Santulis, again, from WPS. For the phase-in, is the phase-in of the claims based on date of service or receipt date? We have paper claims here, too.

MR. MAYS: You'll be responsible for claims as of the first day of contract performance on this contract.

MR. SANTULIS: Regardless of date of service?

MR. AKIN: The initial responsibility will be date of service. The current retail responsibility in the managed care support contracts is based on date of service, so that your initial responsibility will have to be based on date of service.

MR. SANTULIS: Is there doing to be a time period whereby there is a final cutoff in saying any claims beyond this date then go to the new contractor?

MR. AKIN: That will have to be determined based on future decisions with the managed care support contractors.

MR. SANTULIS: So there will be a time here where

there'll be dual processing?

MR. AKIN: There will have to be. Correct.

MR. SANTULIS: Thank you.

MR. MAYS: Any other questions on the phase-in portion?

MR. HARE: Bill Hare, Meridian Consulting. I recall seeing two dates for the actual contract award; one, I believe in July and one in September. Can you provide any further clarification on the expected award date?

MR. KALIL: The award date is going to be based upon when -- or first, how many proposals we get in, and how many we evaluation. At this point in time, we don't expect any extensions. We've not seen any question so far that would require any extensions.

We are looking for, potentially, a July time frame for a contract award. Again, that's really going to depend on what falls out in terms of how many proposals we receive.

If we receive two or three proposals, you know, that would be great. We want to see more than that obviously, and if we do get more than that, then that's probably going to extend the evaluation time. So it depends.

MR. MAYS: Any other questions on phase in? I think everybody is getting hungry. Let's go to phase out, then.

Phase out, at this stage, is fairly generic. We

require a written plan 180 days prior to contract expiration.

One thing to bear in mind is, this contract is based on option periods, and the government is not under any obligation to exercise those options, so you may want to have a basic framework for that plan in your minds at all times, rather than waiting till the fifth option period.

Part of that phase out will require a memorandum of understanding, with the incoming contractor, 150 days prior to the expiration of your contract.

Just to be perfectly clear, when we're talking phase out here, we're talking phase out of the TRRx contract that you'll have here. This one also requires weekly status reporting. It is fairly straightforward. Are there any questions?

Let's look a little on bank accounts and payments. We've got a couple slides here, so if we can get through both of these slides, and then take any questions you may have.

A lot of this we've already discussed with the TEDs, and how that payment process works. As is stated already, there are two bank accounts required; one for the Medicare Dual Eligibles, and one for everyone else that'll be through appropriated funds. The details are all in Section G of the RFP.

We require monthly reconciliation of these bank

accounts to make sure that what was is disbursed from each bank account matches up with the TEDs that have been processed and accepted.

The bottom bullet there is something you may want to pay attention to. If excess funds are drawn from the Treasury, such as paying the pharmacies and beneficiaries more than what has been approved via the TEDs, that must be repaid to the Treasury within one calendar day, or we charge interest. That's just something to be aware of.

MR. KALIL: There's also a penalty associated with that, too, in addition to the interest.

MR. AKINS: There's an additional feature. In addition to charging whatever the Treasury rate is, we're tacking a six percent additional fee on that.

We have had instances through bank mistakes where a bank withdrew for this process, on behalf of whoever the prime contractor was, excess funds. So you need to make sure that you have a very close relationship with your banker, and they're willing to pay the overnight rate, plus six percent, if they withdraw funds inadvertently.

MR. MAYS: And you all thought the Internal Revenue Service was tough. Next slide.

Let's talk about payments. A lot of this we've already talked about. Funds to pay prescription costs are made

available from the Treasury to both bank accounts. I'm sorry. Kevin, do you have a question?

MR. SANTULIS: Yes, Gene. Thanks. Again I'm assuming, and it's not quite stated in the RFP, that TOM requirements are required in this RFP. But are the Chapter 3 requirements for the bank accounts and for the fiscal controls all included in this RFP? Are they included -- need for the ASAP bank account number, fed wire transfers, things like changing the bank account every year by the end of February; all those types of fiscal controls?

MR. AKIN: Yes, I think they're spelled out. ASAP is mentioned at G.1.1.5.1.1. on page 20. But yes, there will be annual fiscal year changes of bank account numbers that the standard set of requirements that existed.

MR. SANTULIS: Should there be a specific reference in the RFP that basically takes you back to the Section 3? Carl, that's what I'm wondering, rather than just -- 'cause I'm wondering if everything in Chapter 3 is actually included in here.

MR. AKIN: Well, if you'll submit that in writing, we'll consider whether we need to do that as an amendment or not.

MR. MAYS: Okay. Back to the payments, again. Payments follow two basic paths; one, payment for the

administrative fee to the contractor, based on the TED records, which follows roughly twenty days after acceptance of the TEDs.

The other one is a payment to the pharmacies which will happen after approval, initial approval of those TED voucher header records, where you'll be authorization to disburse the funds on whatever payment cycle we happen to agree to with you.

TED records that fail edits must be corrected in a timely manner, and the time frames for that are specified in Section G of the RFP. You want to look at that.

Those that are not corrected within those time periods may result in TMA recouping from you, the contractor, both the administrative fee cost, and the pharmaceutical cost. That's something you want to be aware of. Any TED record that fails an edit must be corrected promptly.

I see a question on payments.

MR. CAMILLO: Jerry Camillo, PGBI. When you make the payment, the administrative payment, will there be an electronic file sent along to say what TED records you're paying us for?

MR. AKIN: I think that what we're going to be doing is saying we're paying you for the records submitted with such and such a voucher, minus any of those you've had rejected, which you will have already gotten back information on that.

I don't know if we've determined whether we're actually going to give you list of the individual TED records that we're paying for.

MR. CAMILLO: But when we correct the record, and subsequently you're going to pay me for those, how am I going to know that you're paying me for those when they would have been submitted under the same voucher that the claim was originally submitted under?

MR. AKIN: When we accept them for correction, you would know this.

MR. CAMILLO: But I don't know -- am I supposed to sit there and count and say, this was accepted on this day, not twenty days later. I'm assuming that you're paying for this cleared record. I mean, that's going to be kind of a horrendous reconciliation.

MR. AKIN: If you'll submit this in writing, we'll give you a written response. But we're making certain assumptions about how you set up your accounts receivable, in terms of what you submit, and what we submit back to you, how you reconcile against your accounts receivable.

MR. CAMILLO: Well, when you make the payment, at least reference the voucher number.

MR. AKIN: Yes. The voucher number would certainly be referenced.

MR. CAMILLO: Okay.

MR. MAYS: Any other questions on the bank accounts or on payments?

MR. AKIN: Gene, let me go back to bank accounts briefly. Somebody mentioned in a earlier question, before we got in this section, making periodic payments, or cyclical payments, and making lump-sum payments.

If you are used to writing a single check to Walgreens on a periodic basis, that covers multiple accounts that you have with, we'll say, General Motors, Blue Cross and several state Medicaid agencies, and Walgreen, you're going to have to write them a separate check out of this bank account.

These funds cannot be mingled in some corporate account that you have. These have to be held in a separate bank account, and the reconciliation is against this bank account. So Walgreens, or whoever it may be, may get two checks on the 15th and 30th, or two payments on the 15th and 30th; one from your general fund, if you will, or actually two, one from each of these two bank accounts.

MALE VOICE: I had asked that question, and thank you for addressing it. The government does realize that does not conform to industry, and it may impact the administrative cost of such a program. It's an additional -- it doesn't dovetail well into the structures today. It's not like I'm

adding an existing client.

MR. AKIN: Given that the government is allowing you to draw funds directly from the Treasury, and that you're drawing those funds means that we have to trace them exactly by individual TED, have that capability, we don't have an alternative.

We recognize that industry practice of your commingling the funds from multiple customers is an industry practice, but yes, we recognize that is a departure perhaps from what your industry practice is.

These are not dollars that we are paying to you. We are not doing a cost reimbursement. These are not dollars that we are paying to you and then you are paying to the pharmacy. These are government dollars in a dedicated bank account that populate that bank account, if you will, as the EFT, and checks are presented.

This preserves the money in the Department of Defense, and Treasury accounts so that any interest costs the government would otherwise be incurring, or interest earning, belongs to the government, rather than to its contractor.

MALE VOICE: Thank you.

MR. MAYS: Any other questions? Everything about banks and payments and TED records is perfectly clear? Cool.

Let's talk about financial incentives. We had a few

questions about these. I suppose we'll get a few more.

Our intent here is to incentivize the contractor to maintain the pharmacy network agreements with the most cost effective agreements they can get. The government is basically on the hook with all these dollars, so we're trying to keep our costs as low as possible.

At the same time we recognize that there have to be reasonable rates in order to sign up these pharmacies. So we're looking for your reimbursement rates to be competitive and aggressive at the same time, without going overboard, in the other direction.

Incentive is capped at five percent of any savings on an annual basis, and this will be done at the end of each option period, up to an established cap. And the part that you all love is this negative incentive, where there is no cap, and it's on a dollar for dollar basis. Incentive is calculated by PDTS, again, at the end of each option period.

Why are we doing a dollar per dollar incentive on the negative side? Basically because it's our belief that the pharmacy industry knows the business out there. You've got a very good idea what kind of reimbursement rates you can establish.

You've got the experience, the history, to go out there and set these rates, and we feel that the risk on you of

underbidding these, if you will, is relatively low. That's why we went the way we did with the positive five percent, and no cap on the negative side. Any questions on that.

MR. SPILER: You knew I was going to get up with another network question. I want to go back to the issues I raised earlier around the network coverage, move from the bid, if you will, to now the contractor's engaged in the TRRx program. What is the ongoing obligation of the contractor to maintain a certain level of coverage, if, in fact, the ultimate obligation of that contractor is to manage only access and the discount guarantee?

Let me give you an example. The issue to me is the size of the network. And the way I'm interpreting the solicitation is that there are two burdens to bear on the contractors we have.

One is, to maintain and provide a guarantee discount. The second is to meet an access requirement for urban, suburban and rural. Beyond that there is no obligation either discussed as part of the bid, other than saying the government would prefer minimal disruption. So that handles or addressed, or partially in my mind, the bid obligation.

Once the contractor has the TRRx program, and now I'm obligated to manage discount and access, that gives me, unless there's something I'm missing, all sorts of flexibility to

manage the size of my network to meet those two obligations.

COL. DAVIES: That's basically correct, as long as the access standards are being met, and the guaranteed discount rate, plus dispensing fee, is met in aggregate. That is the primary focus.

I think you'll also see that customer service is a focus in there, also. But from gross perspective, you're correct.

MR. SPILER: Okay. So to go back to a dramatic hypothetical I drew early in the morning, if a contractor or a bidder presents a network with a hypothetical 40,000 pharmacy network, and is able to, at some point, address and meet the financial and access obligations with a network that, for dramatic purposes is 10,000 pharmacies, is that network in that program still to the satisfaction of the government?

COL. DAVIES: Correct.

MR. MAYS: Good. Any other questions on this? Any questions on the financial incentive? Any questions on anything we've discussed this morning so far? We've got a great panel here, so it's a great time to ask questions. Don't have to wait for us to post these on the web.

MS. SCATURRO: Liz Scaturro, MedCo Health. It states in the solicitation that out of network claims were to be reimbursed, just regular bill them out, minus co-pay. Is my

understanding correct there is no financial penalty to a DoD beneficiary for using an out of network claim, and those out of network claims are not subject to quantity limits, PA's and medical necessity reviews?

COL. DAVIES: You have multiple questions embedded in that. Can you break them down one at a time?

MS. SCATURRO: Out of network claims, are they subject to quantity limit, medical necessity and prior authorization reviews?

COL. DAVIES: Yes.

MS. SCATURRO: So there could potentially be a financial --

COL. DAVIES: When you say, are they -- there are disincentives to a beneficiary to use a non-network source, and submit a paper claim. That's especially true if they're a prime beneficiary where there is a point of service penalty associated with that.

So our plan design, just in aggregate is to try and encourage the use of network pharmacies, in order to allow electronic claims processing, et cetera. So the aspect of a non-network claim, all the aspects of the benefit design still apply to that.

Excluded coverage still applies to those non-network claims, or paper claims, as well as the prior authorization

process. That would be a retrospective prior authorization process for one of payment. I think there was another question embedded in that?

MS. SCATURRO: So there's no additional financial penalty to the beneficiary outside of perhaps a difference in quantity they have obtained, versus a difference in quantity that we would reimburse. Nothing else outside of that?

MR. AKIN: There is the potential for, after filling denial, the retrospective prior authorization, which is -- Bill has really been in Washington much too long, when he uses terms like that.

Means that you, in fact, there will be a denial and the beneficiary owes the full amount of the prescription, and so medical necessity is negative determination as well. All of this will come long after some portion of the prescription has been consumed. So if they're using paper claims or out of network pharmacies.

MS. SCATURRO: Thank you.

MR. SANTULIS: Kevin Santulis from WPS. Under what circumstances, could you clarify for us, what explanation of benefits need to be sent to a beneficiary?

COL. DAVIES: For the pharmacy benefit, we do not require in the RFP that an EOB be sent to a beneficiary.

MR. SANTULIS: Would that also include any paper

submitted claims by the beneficiary?

COL. DAVIES: There will probably be documentation provided back to the beneficiary, since you're paying them for that claim. So I guess, do you call that an EOB or do you call that primarily --

MR. SANTULIS: We would refer to it as an explanation of that.

COL. DAVIES: But for electronic claims, it would not be an EOB requirement. For the payment to the beneficiary, there should be accompanying documentation, which in terms would be in the EOB.

MR. SANTULIS: And should that then be included in the RFP as a requirement?

COL. DAVIES: Okay. We'll note that.

MR. SANTULIS: Thank you.

MR. MAYS: Any other questions? Okay. I think you've watched me long enough, so I'm going to turn this over. We do have another question?

MR. LEONARD: Michael Leonard, again, with EHIM. In the case of the incentives/disincentives, how does the percentage of manual claims and dispensing of fees, and average cost from the manual claims impact or not impact the disincentive?

COL. DAVIES: There were some specific questions

that we have received in writing that do address some of the line item issues related to the incentive/disincentive as it is calculated against the guarantee discount rate. The guarantee discount rate really applies to those areas that you, the potential offeror, would have control over. And that's going to be primarily your network pharmacies, and those electronic claims processes.

We can't really hold you accountable for beneficiaries use of non-network services at whatever the billed charges rate would be. So non-network claims would not be included in the calculation for incentive or disincentive.

OHI claims, where we're second payer, could not be included in that process, either, because it would just be impossible to include that as a calculation, because we're paying a very marginal portion of the primary claim.

There may have been one or two others. I can't recall. Those are the two major ones that I could think of that would gain a lot of exposure.

MR. LEONARD: So how does the breakdown of manual claims versus electronically processed claims come into play for calculating the incentive? You come up with an estimate, and if the estimates, at the end of the first option period are dramatically off -- let's say there's 50, 60 percent more manual claims than expected, is there any threshold there that

we have to be concerned with, in how we manage manual claims?

COL. DAVIES: Our expectation is that we try and make sure that we're at the same 97 percent level. We'd like to encourage the use of electronic claims, even higher.

We think that the primary reason that we have 3 percent paper claims today is the fact that those paper claims are generated primarily because of the OHI issue, rather than non-network use.

The beauty of having all the paper claims come in through our contractor will be that it provides you visibility in order to be able to identify areas where possibly beneficiaries unknowingly using a non-network pharmacy can transition to using a network pharmacy.

Or possibly looking at those areas that may be under served and we have non-network pharmacies in there.

MR. LEONARD: And then I have a question that's actually back a couple slides. Maybe point of clarification would be you mentioned that correction of a TEDs record needs to occur within certain periods of time as outlined in the solicitation.

What seems a little confusing is that PDTS is generating a TEDs record. What is an example of a type of correction that a contractor is responsible for making on the TEDs record?

MR. AKIN: You could have provided something that's I'm guessing, that would be an incorrect provider number that we discover after the fact? It's not clear in my mind exactly what data elements you will be presenting, versus what will be used by PDTS to produce the TED.

So I think it would be very rare, given the pre-edit process, that the PDTS is going to do, but there would be something that would bounce back to the contractor that would require contractor correction.

COL. DAVIES: I just want to clarify, too, that 97 percent of our pharmacy transactions come in electronically. And while we don't have a specific standard established in the RFP of how many we would like to see continued or maintained electronically, we feel that the access standards that we've established for our beneficiary population, in order to meet those as network pharmacies, those are going to have to be in place in order, or that the percentage of electronic claims coming in would maintain fairly costs toward or increase, based upon the access and utilization of network pharmacies.

MR. LEONARD: Okay. Thank you.

MR. MAYS: Any additional follow up questions? Any clarification questions?

MR. SPILER: Dave Spiler. I apologize if I missed this in the bid, but specific pharmacy audit. Is there a

provision that will allow the contractor to perform pharmacy audit, and to offset any recoveries attained through that audit to the guaranteed discount provider in the bid?

MR. KALIL: There currently is not a provision in the contract, in the solicitation.

MR. SPILER: Will the government consider that?

MR. KALIL: We will consider it.

MR. HARE: Bill Hare, Meridian Consulting. There are certain sections in the statement of work that does not appear to track into Section L or M. Is it expected, or will there be an amendment that will track those and tell us to respond either in writing or in the oral presentation. I'm referring to a Section C.14, C.15, C.16.3, and there's several more.

MR. MAYS: What we've got listed in Sections L & M are those items that we intend to evaluation, those items in Section C that are requirements that are not listed in Section L or M, will not be evaluated for purposes of determining the successful offeror. They are requirements of the contract, once awarded, but they will not be evaluated as a part of the process. Any other questions?

MS. SCATURRO: Liz Scaturro, MedCo Health. Regarding customer service, there's a requirement for any inbound DoD beneficiaries calls that would be received, if they

had to be transferred or directed to another office for, say, the CSSC, or PVO, or TRICARE Service Center, if that would actually have to be done via what we call a hot transfer?

A customer service representative would have to remain on the line, get that call through, and be sure that it was answered. I understand that's the requirement going external. Is that also the same requirement that's being asked to the rest of these bodies inbound to TRRx?

LTC. DeGROFF: I don't think we can address the inbound portion of that, if I understand your question. Are all the other contractors that are involved in pharmacy supposed to hot transfer calls to the new contractor; is that correct?

MS. SCATURRO: Do they have the same requirement, the managed care support contractors, TRICARE Service Centers?

LTC. DeGROFF: I'll leave that to Col. Davies.

COL. DAVIES: I don't think we can answer that, because we're not intimately familiar with the other contractors. We can take it for the record, but I think it would be very difficult for us to go through each of the contractors and say those were the requirements within those contracts.

I will say there is a great emphasis being put on customer service, from the highest levels within our

department, so that we can assure that our beneficiaries are taken care of in that process. And that's the intent of that particular requirement within the contract.

MS. SCATURRO: Okay. I was asking with regards to having an expectation of staffing, and what could be potentially received at the customer service location.

MR. SANTULIS: This is Kevin Santulis, again. I'm getting the impression, a clear indication, there really is no need to transition from managed care support contractors, the pharmacy data, as part of a transition in step. I mean, we actually have to receive files from them.

COL. DAVIES: That is correct. There would not be a requirement to transfer that data.

MR. SANTULIS: The only problem that I've not been able to resolve in my mind, and how we're going to do that, is if you have an adjustment to do on a previous -- on a claim that's previously processed by the outgoing contractor, after the transition period is over.

COL. DAVIES: That outgoing contractor continues to own that particular claim.

MR. SANTULIS: Okay. Thank you.

MR. MAYS: Good discussion going on. Are there any other questions? Okay. Thank you very much for your participation. I'm going to turn this back over to Don, now.

MR. KALIL: Obviously in any solicitation the government issues, we have a very large number of clauses, certifications and representations to require. We're not going to go through every single one of those.

Certainly, at the time of the post-award conference, if you're the successful offeror, we will go through them in grudgingly significant detail.

So I did want to hit on a couple of the things that are required to come in here with your proposal. One is the Small Business Subcontracting Plan. That is required with your proposal.

Also, we will be requesting other than cost and price and data. There was a question that was raised in the solicitation mailbox, about the fact that we had the clause for cost or pricing data in here, but in Section L, we state that we're asking for other than cost or price data. Section L is what we want, other than cost or pricing data. I am not deleting the clause for cost or pricing data at this time. We are not asking for cost and pricing data. We are asking for other than cost or pricing data.

That is primarily the tables that are in there. I believe it's at L.1. Also, if you have any differences between the Medicare Dual Eligible and the TRICARE Eligible Only, Admin fees, we do want to see some rationale for that.

And then lastly, cost accounting standards are applicable to this contract. Any questions with regard to those three things, or anything else with regard to certifications, representations? Okay. Great. Thank you.

We'll go over the oral presentations. What we'll do is, once we have all the offerors in, all the proposals in, we will basically put the names into a hat, and we'll draw. It'll be a lottery as to which contractor is first in the chute. And that's C-H-U-T-E and not S-H-O-O-T.

We'll schedule those by telephone and e-mail. And then what we're going to be looking is Factor 4, that's PBM Operations. That includes your pharmacy help desk, your prior authorization medical necessity process, the management that Gene outlined before, and that includes your QA plan.

So the management portion of it, beneficiary, member services, and then the other thing is, anything that is written, we do not want to see that in the oral presentation. Anything that is required in the four portions of the proposal, we don't want to see that, if it's written.

I want to emphasize that there is a two-hour time limit, that we do have a maximum of 50 slides, and maybe some can get through 50 slides in two hours and maybe some can't. But if you don't get through your 50 slides within the time period, we will cut you off at two hours.

We don't want any productions. We don't want any outside consultants coming in and putting on your presentations for you. We want the members of your organization that are responsible for those particular areas to put that presentation on.

As a reminder, it is our intention to award the contract without any discussions. We were very successful in doing that with TMOP, and anticipate that we're going to be successful doing that in the retail as well.

So I do ask that you submit your best offer first time around, 'cause it is our intention to issue an award without discussions. Any questions on the oral presentation process? That will be videotaped. We will provide copies of the videotape to you. Okay.

Any questions with regard to anything else we discussed yesterday, today?

MR. FRANCIS: Bill Francis from Med Impact. I'm sorry to keep being redundant about this. But could you define your PA a little bit better? I'm trying to determine how much work I have to do to accomplish that. Medical necessity clearly requires a pharmacist, physician, nurse. PA doesn't say anything about that. And there are some types of PA's that a technician can handle.

So I'm curious as to how I can ascertain, just

looking at your estimated PA volume, how much of those would require higher intervention than just somebody following a protocol.

COL. REMUND: Probably the best place to get an idea about the PA process is to look at the PA web site, which currently contains all the PA's that are currently required by the government, including the criteria for each of the PA's.

That gives you a pretty good indication of the type of questions that need to be answered, in order to make a determination in the PA's, because it's impossible for us to predict with any certain accuracy what PA's might happen in the future.

You have to remember that the drugs that are selected for PA's are selected by the Department of Defense Pharmacy and Therapeutics Committee. And they will, on the uniform formulary, do it for primarily two reasons; trying to make sure that the medications are used in an appropriate manner.

So for instance if there's certain lab tests that need to be done, to ascertain the existence of a certain indication before we provide the medication to the patient, in order to insure safety and appropriate use. That's the type of thing that we're going to be PA,g in the future.

Also, there can be circumstances where for cost effectiveness considerations, that a PA would be put in place.

I think in looking at the existing PA's, you can see that we've tried historically to make it as streamlined as possible, because that's one of the requirements that we're trying to meet in order to provide efficient and effective medication services to our patients.

So we're not in the business of putting in a bunch of prior authorizations to try and squeeze every last penny out of the system, and to avoid spending funds. The focus is on efficient and effective medication use.

MR. McKAY: This is Bob McKay, PharmaCare. Before we leave, could you address in broad terms and from your perspective, how the contractor could find themselves at financial risk under this agreement?

I think that's important. We need to have a sense of that, with respect to both financial risk associated with anything to do with claims payments, not necessarily associated with the incentive process, either. We understand that pretty well.

MR. KALIL: I think the financial risk here is really, from our perspective, not really with the payment of the administrative fees. It's isn't really with the payment of administrative fees. It's certainly with you being able to maintain that guaranteed network discount.

MR. McKAY: I'm petrified obviously with any

opportunity where I pay a pharmacy and I then don't get the funds. That's what I'm worried about.

COL. DAVIES: That's because these funds are paid on a government account. And that's the rationale for that concept.

MR. McKAY: Thank you.

MR. KALIL: Any other questions? Okay. If you do have questions, please do submit those. Dave, if you would submit the one you asked me about the offset, if you'd submit that in writing, please, I'd appreciate that.

Again, register on the solicitation web site. It's the best way for you to get information regarding the solicitation as it comes out.

Also, retail.solicitation at tma.osd.mils, where you can submit those questions. And I thank you for your participation, for your questions. Have a safe trip home, and good luck.

[TRICARE TRRx Pre-proposal Conference concluded.]

C E R T I F I C A T E

STATE OF COLORADO)
) ss
COUNTY OF ARAPAHOE)

I, Laura M. Machen, an independent transcriber and notary public within and for the State of Colorado, certify the foregoing transcript of the tape recorded proceedings, **In Re: TRICARE TRRx Pre-proposal Conference, April 3, 2003,** and as further set forth on page one, is reduced to printed form by computer transcription, and dependent upon recording clarity, is true and accurate, with special exceptions of precise identification of any or all speakers and/or correct spelling of any given or spoken proper name or acronym.

Dated this 6th day of April, 2003.

My commission expires May 23, 2004.

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